

**CARETAKERS AND THE RIGHTS OF THE INSANE:
AN HISTORICAL SOCIOLOGY**

Patrick Anthony Leiba

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ABSTRACT

This investigation grew out of my experiences while working as a mental nurse with people deemed to be insane. The behaviours which they presented and the medical and legal control exercised over them became of concern to me because I felt their rights were not being respected. A primary issue is the extent to which adherence to the medical-somatic view of insanity held by psychiatrists, lawyers and politicians has led to the exclusion of viable custody and treatment alternatives.

The purpose of this research is to question the role and functions of mental nurses. It suggests that 'caretakers' might be a more suitable title for such workers with the insane. The hypothesis underlying the research links the work of 'caretakers' of the insane to changes in government policies and legislation; the thesis examines this hypothesis in the light of changes in the roles and functions of 'caretakers' over the period from 1890 to 1990.

Research activities included the examination of primary sources, Hansard, newspapers, and professional journals. Interviews were also carried out with nine contemporary caretakers who have worked with the 1959 and the 1983 Mental Health Acts. These research methods provided an historical background to the debates in the Houses of Parliament when mental health legislation was discussed; information from the writings of the professionals who worked with the insane at the times of new mental health legislation; data on the public and media debate of these issues; and information on the perceptions and duties of caretakers working with the insane at the times of new mental health legislation.

The research findings show that both those who cared for the insane and the insane themselves have been subjected to changes brought about by mental health legislation since 1890. These changes affected the working conditions of the caretakers and the social control and rights of the insane. The changes in the work of caretakers led to new directions in their education. Workers with the insane became a part of nursing by adopting the somatic approach to care.

When this occurred, many of the care activities of keepers, attendants and mental nurses became redundant. Over time, there has been a move to, and then away from, the clinical-somatic model of nursing towards caretaking skills such as group work, therapeutic community skills, counselling skills and psychotherapy skills. These caretaking skills are seen by contemporary caretakers as going beyond their custodial and social control functions, towards providing a space in which people can be respected, encouraged, supported and be open to new insights.

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CHAPTER 1 FOCUS, BACKGROUND AND DESIGN OF STUDY

The subject of this thesis is the work of the caretakers of people deemed to be insane or mentally ill. The thesis makes an important new contribution to our understanding of the nature of the work carried out by people charged with the responsibility of looking after the insane.

The thesis spans several important areas and disciplines; the sociology of the health and welfare professions; the social construction of mental illness; the historical development of medical treatments for mental illness; the evolution of civil rights and liberties; and the relationship between law and the legal system, on the one hand, and social practices and policies, on the other. The central hypothesis of the investigation is that the work of the caretakers of the insane has changed with changes in government policies and legislation.

The work described in this thesis therefore contributes directly to the knowledge available on the professionals who work with people deemed to be insane. The investigation examines the role of the function of mental nurses and the changes that took place in caretaking activities over the period from 1890 to 1990. It argues that over this period the workers with the insane became a part of nursing by adopting the somatic approach to care. As a consequence, many of the traditional care activities of keepers, attendants and mental nurses became redundant.

The focus of the investigation

A number of important questions proceed from the central hypothesis of the study. These include: how do government policies and legislation influence the roles and responsibilities of the caretakers and the rights of the 'insane'; and how does the work of caretakers of the insane relate to changes in social and legal definitions of insanity? The thesis seeks answers to these questions

through an examination of documentary/historical sources and a qualitative study of contemporary caretakers. Its primary emphasis is on the evolution of caretaking work in the UK.

By developing the concept of 'caretaker', the thesis reflects on the titles workers with the insane have used or have had thrust upon them during the period under study. In the thesis, the single title 'caretaker' is used to denote all those workers referred to as attendants and mental nurses. This term embraces the medical, the social, the psychological, and the philosophical, as well as the concern for users' rights and their active participation in their own care. 'Work' in this context includes both the formal and informal roles of caretakers and their responsibilities and rights in relation to the insane. The underlying assumption here follows Rose's (1986) suggestion that the picture presented by a benevolent psychiatry could be considered illusory, in that its treatment and institutional regime may be experienced as degrading, dehumanizing and damaging. The thesis argues that it is largely within this web of social control that the caretakers of the insane have operated.

The selection of the period from 1890 to 1990 period gives the thesis a defined focus, offering both historical and contemporary evidence. This period was chosen to include the 1890, 1930, 1959 and 1983 Mental Health Acts, so that issues around reform and civil liberties and rights could be addressed.

Background

The men and women who care for the lunatic, the mad, the insane and the mentally ill have had a long history and a variety of titles. In the Middle Ages, care was provided by a care worker called 'master' who appointed men and women to administer to the needs of the insane in special institutions. The master was supposed to be a priest who managed the institutions with the

help of guardians and wardens. In almshouses, the master was also known as 'custos', 'keeper' or 'rector'. In the eighteenth century, care was provided by keepers and attendants, and in the nineteenth and twentieth centuries by attendants and mental nurses. These changes in the titles of workers with the insane in institutions have reflected altered conceptualizations of the insane by workers themselves, and by the medical and legal establishments.

Carpenter (1980) argues that the men and women who look after the insane seldom achieve public attention except as a result of scandal or a case of alleged ill-treatment. The literature on the history of psychiatry and nursing documents the work of doctors with the insane in madhouses, asylums and mental hospitals. But, as Walk (1961) observes, nursing and psychiatric histories almost completely neglect the carers of the insane, despite the fact that it was (and is) the twenty four hour a day work of caretakers in watching and caring for the insane that has been central to their social control and management. The study described in this thesis is an attempt to remedy this situation. Are caretakers custodians, carers, advocates or the police of the insane? The research sheds light on the culture formed by caretakers, on their organization, the extent to which they have autonomy as professionals, and the kinds of control they have exercised over the insane within institutions.

Insanity is, of course, a highly problematic concept, and the thesis also attempts to address changes in the social definition of insanity. The problematic nature of the concept of insanity derives from the fact that religion, law and medicine provide the rationale for the labelling and the management of the insane: religion through a variety of ritual practices aimed at the spiritual; the law through the management of crime and the surveillance of populations; and medicine through the control of the body (Turner 1987).

According to Carpenter (1980), the early asylums were governed by books of rules issued to staff. Some of these rules were circumscribed by law, for example, Sections 322-24 of the Lunacy Act, 1890, made the neglect of patients or the helping of patients to escape punishable offenses. However, the existence of rules did not guarantee compliance, and as Scull (1979) has argued, medical superintendents were increasingly removed from the day-to-day functioning of the asylum, and there were few assistant medical officers to deputize for the superintendents. This meant that the attendants were left largely unsupervised, and were heavily depended on for the case reports which were used to determine treatment. In Scheff's (1961) study of a mental hospital, despite administrators' attempts to change traditional treatment and care policies, these changes were frustrated by the staff, and in particular by the attendants. Scheff's work is of interest because it questions how and why the staff were able to resist the changes introduced by the administrators. In his study, the staff were effectively able to do this because, being left unsupervised, they could interpret the administrators' policies to suit themselves. The staff also belonged to a stable and well-organized community. Within this community and over the years they had developed an informal system of sanctions to keep discipline in their own ranks. Such a system was able to neutralize the staff who wished to accommodate their work to the changes desired by the administrators.

Scheff's study raises important questions about the informal social organization of caretaking work. Unsworth (1987) has observed that the 1983 Mental Health Act affected the division of labour in asylums by allocating different roles to different sets of personnel. While maintaining the hegemony of the medical profession, the Act accorded new roles to other social and health care workers. Unsworth sees the law as restricting the power of the professionals working with the insane in the interests of civil liberty and accountability in their functions as social control agents.

The issues around the law and services for the insane in the civil sphere are an area of tension. Jones (1972:155) has argued that a legal approach to insanity is '...piling safeguard upon safeguard to protect the insane against illegal detention, delaying certification and treatment until the person genuinely in need of care was obviously (and probably incurably) insane'. Jones's critique of legalism comes from a perspective of sympathy with a social welfare approach to insanity. For her, insanity is a social administrative problem, an element of social policy.

Although the work of caretakers is under-researched, some work has been done. In the history of nursing, work with the insane receives mention, but in a limited sense. The question here is: does the caretaking of the insane have a separate history from nursing, and if so what is it?

Research methods

Methodologically, this is a qualitative investigation. Two main research methods were used: historical investigation and documentary analysis; and interviews with contemporary caretakers. The use of the two approaches enables the work of contemporary caretakers to be compared with that of their predecessors. The historical background is essential to the study's main hypothesis concerning the relationship between caretaking work and mental health legislation.

(a) Historical investigation and documentary analysis

Primary and secondary sources relating to the period from 1890 and 1990 were examined using the following archives and libraries: the Bethlem Hospital Archive, the Royal College of Psychiatry Library, the National Mental Health Association Library (MIND), the Wellcome Institute for the History of Medicine Library, the British Museum Newspaper Library, and the South Bank University Library. The main documentary sources consulted included: Bills of Parliament and Mental Health Legislation; Reports of the Lunacy

Commissions and Board of Control; Reports of the Societies concerned with the reform of legislation, for example, The Mental Patients' Union, MIND and similar organizations; the Report of the House of Commons Select Committee on Lunacy Law, 1878; the Special Report of the Commissions in Lunacy to the Lord Chancellor on the Alleged Increase of Insanity, 1897; writings of workers with the insane, including the work of Sam Roberts, a 'Madhouse' Keeper at Nathaniel Cotton's house, St Albans; Records of the Asylum Workers Union; Tuke's writings on the Moral Management of the Insane at York; Hansard 1890-1983, and especially speeches made in the House of Commons and the House of Lords relating to mental health at times when Mental Health Act Green Papers were debated, and around the passing of the 1890, 1930, 1959 and 1983 Mental Health Acts.

(b) The collection of information from contemporary caretakers

A sample of caretakers who have worked with the 1959 and the 1983 Mental Health Acts was interviewed using a semi-structured interview schedule. Nine experienced caretakers (mental health nurses) from different care settings were interviewed. An interview to provide data on his own reflections was also carried out with the researcher who has worked as a Registered Mental Nurse.

Access and ethics

Ethical concerns arise in relation to several aspects of the research process (Kidder 1981). Ethical issues may be generated by the kinds of questions studied, the methods used to obtain information and answers, the procedures used to choose subjects, how subjects are treated and the uses to which data are put at the end of the research. Some of the historical documentary materials consulted for the research were clearly collected without the knowledge that data might be used in this way. This situation presents something of a dilemma in relation to the ethical requirement that the rights of those from whom the original data were gathered should be respected.

Access to the Bethlem Royal Hospital Archive and to other relevant documents was gained by writing to the archivists, librarians or information officers with a synopsis of the research interests and a request for access. Attention was paid to any necessary considerations of confidentiality. The caretakers who were interviewed were all given full information about the research both verbally and in written form, and any requests they made concerning the conduct of the interviews and confidentiality were respected. Their freedom to decline to participate or to withdraw at any time was respected.

Organization of the thesis

The next chapter provides details of the plan of the investigation and discusses the methodological issues and the methods employed in the study. The advantages and disadvantages of doing historical social research are presented, and the case for the use of primary and secondary sources, documentary analysis, interviewing and incorporating the reflections of the researcher is argued.

Chapter three is concerned with the theoretical approaches underpinning the investigation. The theoretical approaches of power and social control in the context of medicine and insanity are explored. The role of medicine in contributing and maintaining medical power and social control is discussed, along with some of the ways in which mental health laws provide for the social control of persons deemed to be insane.

Chapter four looks at the arguments, the debates and the evidence concerned with defining insanity, madness and mental illness. The social dimension of insanity, particularly the relationship between social values and psychiatry, is addressed. Alongside these debates are the experiences of users and their organizations which work to sustain them as psychiatric survivors.

In chapter five, issues concerning madness in relation to gender, social class and ethnicity are addressed. The debates as to how psychiatry is used within oppressive and racist societies to control women and black people are presented.

Chapter six deals with the suggestion that the caretakers for the insane perform their roles and responsibilities differently from nurses. This suggestion rests on the idea that caretakers, at the same time as carrying out their care activities, engage in significant social control functions.

Chapter seven details the mental health legislation enacted between 1890 and 1983. The main provisions of the Acts are outlined, as are their intended functions in relation to the social control of the insane, the provision of care and the protection of rights.

Chapter eight is concerned with legislation, caretaking and rights. Evidence from Hansard and reports in the Times newspaper which are relevant to the 1890, 1930, 1959 and the 1983 legislation are examined to see what they say about the impact of these laws on the work of caretakers and the rights of the insane and mentally ill.

Chapter nine looks at changes in caretakers' roles between 1890 and 1990 using the same documentary sources: Hansard, Journals and the Times newspaper reports.

Chapter ten presents the views of contemporary caretakers about their roles and functions in providing care and treatment, about the rights of users and the social control of users.

Chapter eleven discusses all the evidence drawn in the investigation, and chapter twelve concludes the report by providing a summary of the

arguments and some suggestions about how the work of caretakers might develop in future.

CHAPTER 2

DOING HISTORICAL SOCIOLOGY: METHODOLOGICAL ISSUES

To do sociology without reflecting on the past is a one-sided exercise. This chapter discusses what it means to undertake historical sociology. It includes a detailed overview of the dominant epistemologies within sociological research, and also explores the advantages and limitations of the methods of documentary analysis, interviews and autobiography.

History and sociology

As Erickson (1973), amongst others, observes, the relationship between sociology and history is beset by debates and arguments. There is, nevertheless, an underlying insistence that sociologists should devote more attention to history. Traffic across the boundary dividing sociology and history has increased by historians seeking new techniques to help in their ordering of the past in social terms, and by sociologists who are interested in the rich sources of data located in the historian's archives. Sociologists might also profit from being able to employ historical methods to assist in the analysis of sociological data. The scope of sociological enquiry can be broadened by the systematic study of the past. For example, paying attention to historical method may enhance the acquisition of a sharper sense of relationships between social events over time.

Wright Mills (1959) has insisted that the sociologist is really a contemporary historian; he/she is observing the history of the age, as well as looking for broader indicators of regularities and laws. In the course of this a setting that appears to reflect certain general social properties may later be demonstrated to have been but a part of wider changes. Perhaps history written with a sociological awareness has something to offer sociology, by restoring the methods employed by the early pioneers of sociology such as Weber, Durkheim and Marx. Sociology has certainly been criticized for

departing from the historical concerns of the nineteenth century European founding fathers. There are many examples of studies in which sociological researchers have made errors by ignoring historical evidence. Thernstron (1964) gives one illustration of the weakness of an historic sociology in a critique of Warner's (1959) Yankee City series of studies of a New England Community. Thernstron argues that Warner misinterpreted a number of patterns by relying on contemporary reports of past patterns and by ignoring the actual history of the community as available in documentary sources. Carr (1961) has suggested that the more sociological history becomes and the more historical sociology becomes the better it is for both, as this leads to an open frontier allowing for a two way traffic.

In his paper 'The Relevance of History To Sociology', Goldthorpe (1962) discusses the relationship between the two disciplines and touches on the philosophical origins of the differences and the ways in which the two subjects have impinged upon one another. Attempts to establish strict distinctions between sociology and history have been concerned with studying their respective logics and methods. Perhaps the most forceful case which has been made for creating a distinction between history and sociology rests on the differences between 'idiographic' and 'nomothetic' disciplines. An idiographic discipline such as history is held to be concerned with unique and particular events or instances which are studied for their intrinsic interest. By contrast, a nomothetic discipline such as physics or chemistry is concerned with the formulation of general propositions through which practitioners seek to understand, and to explain, the class of phenomena which constitutes its subject matter. Sociology has been placed along with the natural sciences in the nomothetic category as being an essentially generalizing discipline. The sociologist in his/her quest for general propositions about society has to develop extensive conceptual schemes to analyse, reduce and order the diversities of our social existence. The historian, on the other hand, is said to have little interest in such general concepts, but to be interested in

developing even more reliable and penetrating methods of ascertaining historical data. Thus the sociologist and the historian are represented as working on quite different levels of abstraction.

These arguments have attempted to draw strict lines of demarcation between history and sociology, but they involve considerable difficulties. For example, the attempt to distinguish sociology from history on methodological grounds requires that sociology be restricted to the study of present-day societies, and that the scope of the subject being studied and researcher be restricted in terms of research methodology, methods and techniques. Goldthorpe (1962), considers that studies on 'classic lines' remain of crucial importance to contemporary sociology. Studies which focus on patterns of variation in social structure and in culture are those most likely to help in the sociologist's effort to explain societies and their social processes at the present time. Through comparisons with other cultures, historically as well as geographically, social existence may be made more intelligible.

Historical method: problems and possibilities

Best (1970) has argued that there are problems in doing historical research. For example, there is a need to have the relevant historical knowledge to understand the period under study. The problem of meanings, both denotative and connotative, must be carefully reflected on, as meaning and words not only change from generation to generation, but may also be context-specific. According to Borg (1963), historical research is the systematic evaluation and synthesis of evidence in order to establish findings and draw conclusions about the relationships between past events. Researchers must reflect on evidence; evidence is interpreted, and different people looking at the same evidence often ascribe different meanings to it. A researcher's reconstruction of the past is easily distorted. Lewenthal (1985) has argued that the researcher is more aware of events occurring prior to, and after, the period or events studied. This awareness, he suggests, gives

the researcher a greater, and more artificial, sense of coherence than was experienced by those living in the past. A researcher's broader awareness can create the illusion that things happened because they had to, or that they fit together neatly.

Foucault (1967,1972,1976,1977,1980), challenges much of what passes as historical investigation. His work, from the early **Madness and Civilization**, to his recent **History of Sexuality**, can be seen as history, or to use his own terms an 'archaeology'. Knowledge, for Foucault, is constituted by ruptures in previous ways of thinking. His concern has been with discontinuities in thought, and the impact which these ruptures have had on the delimitation of truth. In his history he rejects claims to be practising science. At the beginning of his 'Archaeology of Knowledge' he evokes the French Annales school approach to history which stresses the study of change in material civilization over periods as long as a millennium, as well as the layered and overlapping time scales of historical transformations. The Annales influence is evident in his advocacy of what he calls a 'general' history, as opposed to a 'total history'. Total history, for Foucault, is attempting to draw all phenomena around a single causative centre, so that the same form of historical influence is thought to be operating at all levels in a society at the economic, social, political and religious levels. On the other hand, general history is concerned with series, segments, limits, differences, time lags, anachronistic survivals and possible types of relationships. The task proposed by general history is precisely to determine what relations may legitimately be made between the various forms of social categorizations, but this is done without recourse to any master schema, or any ultimate theory of causation. Most past histories, Foucault argues, have been concerned with reading documents for hidden meanings; his concern is, rather, with an understanding of the conditions for the emergence of particular forms of knowledge, and with an analysis of the past to discover traces of the present.

Cicourel (1964) sees the use of historical materials as a method depending on materials produced in the past. These materials are unique records and expressions of behaviour, and the sociologist seeks to reconstruct and to analyse them by means of a set of interpretive categories. Such materials are useful for suggesting hypotheses, testing them, and helping to establish a general perspective in which to place contemporary sources of data. Cicourel also views historical materials as containing built-in biases which the researcher might be unaware of as he/she has no access to the settings in which they were produced. Gottschalk et al. (1947) rightly insists that historians must ensure that their data really do come from the past and that imagination is directed toward re-creation and not creation. He suggests that there are at least three ways in which the present determines how the historian may interpret the past. Firstly, there is the inescapable tendency to understand others' behaviour in light of one's own behaviour patterns. Secondly, the contemporary intellectual atmosphere is a deciding factor in the historian's choice of subjects for investigation. Thirdly, there is the historian's exploitation of current events; from the episodes and developments of his/her own day the researcher may draw historical analogies to the episodes and developments of the past.

Berelson (1952) refers to the notion of 'communication content'. This is the set of rules used by the researcher to categorize and make sense of the materials he/she is researching, and the effect which these rules have on making sense of, and communicating, the information found. When the sociologist uses official records of a mental hospital, or a prison, some form of communication content analysis occurs, as a response to the challenge of making sense of often abstract, highly condensed and incomplete records of complex events. Organizations themselves develop various ways of communicating official and unofficial material which are not formally recorded. Berelson (1952) asks researchers to remember that official records are often written for a particular audience, usually with a view to enabling the organization to be seen at its

best. He also points to other impinging factors, such as the public and private character of the meanings in such documents, the language used and the cultural and sub-cultural definitions which are employed. Naturally occurring social situations can be studied from records which are available. For example, in his study of suicide, Durkheim's (1951) primary hypothesis was that a basic cause of suicide is lack of integration in a social group. He examined three kinds of social group integration: religious, familial and political. He found suicide rates to be lower among Catholics than among Protestants, lower among married people than among single people, lower among those with children than those without children, and lower during periods of national fervour. Durkheim argued that all these findings supported his hypothesis that belonging to a cohesive social group is a deterrent to suicide.

Documentary analysis

Documentary and archival studies such as Durkheim's rely on the analysis of data collected for purposes other than those of the particular study. Critiques by Douglas (1976) of Durkheim's research on suicide point out that the over-reliance on official records and official statistics may deny the impact of the social processes involved; for example, in deciding which cases were those of suicide and which were not. The social meaning of suicide is problematic. It is important for researchers to guard against any uncritical acceptance of official records and official statistics.

Primary sources which have survived may be published or unpublished; these are excellent documents from which to study past social activities. As Newman (1991) points out, a frequent criticism of such documents is that they were largely written by elites or those in official organizations: thus the views of the illiterate, the poor and, in this research, the insane, may be overlooked. For example, it was illegal for slaves in the United States to read or write, and thus written sources on the experience of slavery have been

difficult to find.

An additional issue is that there are sometimes rules of confidentiality which allow access to documents only after certain periods of time has passed. For example, the Bethlem Archive records are open when they are thirty years old, but records containing information relating to individual patients are closed until they are one hundred years old.

Researchers may have a tendency to use easy-to-find secondary sources rather than sufficient primary sources which are harder to locate but are usually more trustworthy (Best 1970). Information may be inadequately criticized by, for example, accepting a statement as necessarily true when several observers agree, and not realizing that they were all influenced by the same inaccurate source of information. Simplistic analyses may fail to recognize the multiplicity and complexity of past events. Finally personal bias and distortions may be revealed by statements lifted out of context and in an uncritical manner, or by an unrealistic admiration for the past or an equally unrealistic admiration for contemporary events.

Studying the caretakers of the insane

The present research attempts to reconstruct through critical historical and contemporary enquiry the nature of caretakers' work with the insane. The value of selecting this method lies in facilitating an analysis of how past mental health legislation affects present legislation, in generating information from the past which throws light on the question of how the rights of the insane were, and are, addressed, and in permitting an analysis of any changes in the role and responsibilities of the caretakers of the insane.

(a) Analysing relevant documents

Information was gathered from selected primary and secondary sources within the United Kingdom. The primary sources include the relevant Mental

Health Acts, Hansard, information in the Bethlem Royal Hospital Archive, research reports and official publications. The verbatim parliamentary record of what is said in the House of Lords and the House of Commons is possibly the most trusted official record (Mann 1985). A member of parliament may deeply regret what he/she said in the heat of a debate, but he/she can never have the record changed. He/she can only have it corrected if the official Hansard writers can be shown to have misreported what was said. The situation however, is different in the U.S.A., where the Congressional Record proofs are submitted to the Congressperson, who can alter the proofs to eliminate his/her peccadilloes. The secondary sources include the writings of caretakers of the insane, journals relevant to medicine, nursing, health and the insane, and contemporary newspapers, books and articles.

All these historical records and materials were subjected to careful assessment, categorization and selection, attention paid to authenticity as argued by Platt (1985). The historical data were evaluated through historical criticism which consists of two activities: the authenticating of the source (external criticism); and an evaluation of the worth of the information (internal criticism). External criticism is aimed at discovering frauds, forgeries and distortions. One way of checking is to ascertain whether the information a document contains is consistent with what is known about the period or area of study from another source. Another approach is to ascertain if the document has been 'ghosted', that is, prepared by a person other than the alleged author or signer. Internal criticism means evaluating the accuracy and the worth of the information contained in the document.

(b) Interviews with contemporary caretakers

Information was also collected from caretakers working in different mental health care settings (community, hospital and education), who have had experience of the working of both the 1959 and 1983 Mental Health Acts. The aim here was to obtain information and to attempt a comparison of the

provisions and workings of the 1959 and 1983 Mental Health Acts in relation to any changes which came about in relation to the roles and the responsibilities of caretakers, and any changes in relation to the caretakers' role vis-a-vis the rights of the insane.

Nine respondents with substantial experience of caretaking work took part in a semi-structured interview. The interviews lasted for half an hour and they were tape-recorded. The nine respondents included: a manager of mental nurses in-service education, a manager of hospital and community services, a manager of staff delivering community mental health services, a teacher of mental nursing in a hospital training school, a teacher of mental nursing in a university, a clinical nurse specialist working with drug abusers in the community, a teacher who trains mental health nursing teachers, a mental nurse/counsellor who practices as a teacher practitioner and the researcher, who is a trained mental nurse.

The interview schedule contained some structured questions and the respondents were allowed to build themes and provide their own accounts. It was of the open-ended type, which, as Kerlinger (1970) argues, supplies a frame of reference for respondents' answers, but puts a minimum of restraint on the way they express these. Open-ended questions are useful because they are flexible, allowing the interviewer to probe so that depth can be achieved, and for opportunities to clear up misunderstandings, encourage co-operation, and help in establishing and maintaining rapport. Such questions may also result in unexpected or unanticipated answers which suggest new relationships between variables.

There are, however, problems. A main one is bias. According to Cohen and Manion (1987), bias may be reduced by careful formulation of questions so that their meanings are clear. Another problem which Kitwood (1977) highlights is the issue of reliability and validity. He argues that, where

increased reliability of the interview is brought about by greater control of the questions, this is done at the cost of reduced validity.

The interviews with the nine caretakers were sympathetic to Oakley's (1981) view that successful interviewing should validate the respondent's subjective experiences. The interviews allowed the respondents to question the interviewer and so maintain rapport in a honest, warm and friendly way. A balance was aimed at between friendliness and a 'researcher-respondent' relationship. The personal and social situation generated by the interview was recognized rather than ignored. My own position as researcher, being male and black and an ex-caretaker, might have affected interviewer-interviewee interactions. My experiences as a caretaker for the insane meant that I had some knowledge of the situations the interviewees were describing, and the language used by interviewees was also familiar; this allowed the interview situation to be more of a collegiate relationship with interactions emphasizing equality.

In interviewing myself, I allowed my own reflections on the questions in the interview schedule to be collected in a manner similar to that of the other respondents in the study. The reflections of the researcher can be considered as potentially biased information because of his closeness to the context which is being researched. Hammersley and Atkinson (1983) argue that in self-interviews of this sort researchers may have an interest in presenting themselves favourably; they may have axes to grind, scores to settle, or excuses and justifications to make.

Following Kohli (1981), the self-interview is an auto/biographical method which is defined as a text that represents the participation of the author in a specific social situation by drawing on his/her personal conception of that situation. As Stanley (1993) has argued, the auto/biographical method in general as a data resource tells us something about life 'out there'; some

auto/biographers describe events as they occur, thus representing feelings happening in a current situation, while other auto/biographies are written years after the event and so rely upon the vagaries and tricks of memory. Barthes (1975) expresses this in terms of the self who writes not having an unproblematic access to the past; the past, therefore, has to be recovered in traces rather than as a whole.

The qualitative/quantitative debate

The research enterprise described in this thesis is primarily a qualitative investigation. It seeks to generate a rounded indepth account of the work, role and responsibilities of the caretakers of the insane. This approach to research is well documented in the field of anthropology, and is not a new tradition, but one which saw a resurgence in the 1960s, which has resulted in it being a conspicuous force in social science research today.

The concept of methodology within social research embraces a mixture of philosophical issues and considerations of the advantages and disadvantages of the approach, perspective, tradition or paradigm used in the collection of data and evidence. Debates within methodology address the two traditions of quantitative and qualitative research. Such debates look at the underlying philosophical positions and at their differences or similarities.

The quantitative research tradition is usually depicted as exhibiting many of the procedures of the natural sciences. Quantifiable data on large numbers of people who are known to be representative of a wider population are generated in order to test theories and hypotheses. In following this tradition, many practitioners view their activities as capturing the essential ingredients of science. Interest in this debate can in part be attributed to Kuhn's (1970) work on the history of science. The most influential aspect of Kuhn's thesis was that of a 'paradigm', a cluster of beliefs and dictates which for scientists in a particular discipline influence what should be studied, how research

should be done and how results should be interpreted. Feyerabend (1975), a philosopher of science, has remarked on the dangers of introducing such issues into the language of the social sciences; he accuses Kuhn of encouraging people who have no idea of science to talk with assurance about the scientific method. This incursion of broader philosophical issues into the study of methods conveys the notion that methodology is a complex philosophical and conceptual domain.

The main characteristic of qualitative research is its expressed commitment to viewing events, actions, norms, and values from the perspectives of the people who are being studied. It is contrasted with quantitative approaches which are concerned with testing theories, while qualitative approaches are deployed in order to generate theories. Social scientists who see quantitative and qualitative research as separate paradigms have produced ideal-type descriptions which obscure the areas of overlap, both actual and potential, between them (Bryman 1988). Any assertion which associates quantitative and qualitative research with different epistemologies is questionable, once the actual practice of social research is examined. For example, a good deal of qualitative research shares a quantitative empiricist agenda, and much quantitative research embodies a concern for subjects' interpretations, which is assumed to be the arena of qualitative research.

Quantitative and qualitative research can therefore be understood as views about the ways in, and by which social reality ought to be studied; as such, they embody different combinations of epistemological assumptions as to what should pass as warrantable knowledge about the social world. Bulmer (1991) characterizes a variety of views which sees social scientists as taking on the issue of quantitative versus qualitative approaches. Some see quantitative and qualitative research as demonstrations of different ways of conducting social investigations, appropriate to different kinds of research questions and methods. Bulmer further contends that the two approaches are

more than merely different kinds of research methods; they also involve different styles of exposition. For example, the employment of a scientific rhetoric, an experimental research design and concepts of 'variables' and 'control' in quantitative research impose expectations on the reader about the sort of framework that is about to be encountered. The self-conscious endorsement by many qualitative researchers of styles of presentation and literary devices which entail a rejection of a scientific rhetoric, can be seen as a countervailing genre. Qualitative researchers, through rejecting the scientific idiom and the adoption of a different framework, expect their work to be read and judged within the confines of that framework.

Many social science researchers have become progressively disillusioned with the products of the scientific quantitative approach. According to Bryman (1988), in quantitative research the researcher's contact with the people being studied is fleeting or even non-existent; indeed many methods associated with quantitative research may require no contact with subjects at all. Quantitative researchers adopt a posture of outsiders applying a pre-ordained framework to their 'subjects'. Subjects can therefore be considered to be largely 'fodder' for the researcher's concerns, rather than people with their own views and perspectives in relation to the area being investigated.

Max Weber's idea of *verstehen* is one of the intellectual precursors of the qualitative approach. Weber placed *verstehen* - understanding - at the forefront of his view of what sociology entails: 'Sociology is a science which attempts the interpretive understanding of social action in order to arrive at a causal explanation of its course and effects' (Weber 1949:90). The suggestion that Weber's *verstehen* has been a major influence on qualitative research has been challenged by Platt (1985). In her research on the history of qualitative research, Platt points out that early qualitative researchers of the 1920s and 1930s appeared to be unaware of the concept; while those of the 1940s and 1950s were either unaware of it or did not regard it as relevant.

She further argues that qualitative researchers had access to other theories such as those of Cooley (1902) and Thomas and Znaniecki (1918-1920), whose work converged with Weber's. Perhaps the use of Weber's *verstehen* as an intellectual precursor of qualitative research is a source of legitimation for a tradition which has been a poorly regarded paradigm when compared to the widespread acceptance of quantitative research.

Doing qualitative research embraces the philosophical tenet of naturalism. In quantitative research this concept is interpreted as the applicability of the natural science model to the study of the social world and social reality. However, in qualitative approaches there is another interpretation of the meaning of naturalism. Matza (1969) and Randall (1944) have pointed to a meaning of naturalism which implies that the researcher should treat the phenomenon being studied as naturally as possible, so as to avoid or minimize the adulteration of the setting and strive to remain true to the nature of the phenomenon under study. Thus naturalism, in this sense, departs from the practices of quantitative researchers, who are thought of as imposing their own conceptual schemes on the social world.

The ethos of the qualitative approach fits well the concern in the present work of trying to examine the intersubjective world of the caretakers of the insane - that is, searching for evidence which offers an analysis of the meanings caretakers have of their work, their roles and their responsibilities. The attempt here is to focus on trying to understand the events, actions, norms, values and perspectives of the caretakers being studied. There are difficulties in achieving this, as Birkstead (1976), amongst others, has found. Birkstead focused on his subject's interpretation of social reality, and examined academic performance at school from the perspective of the students. But how feasible is it to perceive as others do? This concern over interpretation has been discussed by McNamara (1980). McNamara examined a brief transcript from Keddie (1971). A boy asked the teacher, 'How do you

unlearn?' The teacher replies, 'Well, you simply forget'. This response is interpreted by Keddie as devised to render the question unproblematic. The question McNamara raises is, how does Keddie know that this is what the teacher intended? Such concerns also surface when there are differences of opinions between two researchers looking at the same data.

An open and unstructured research strategy allowing for flexibility, rather than one which is rigidly pre-defined, is the preference in qualitative investigations. The argument is that an open research strategy enhances the opportunity of coming across unexpected issues. Critics of this approach could argue that such an open approach ignores the need to ground research in a problem. The commitment to openness and flexibility varies considerably between researchers and the topic area being researched. For example Ditton (1977), writing about his ethnographic study of 'fiddling' in a bakery, affirms that his research was not set up to answer any pre-set empirical questions. His decision to concentrate on 'fiddling' was not made until a considerable proportion of the research had already been conducted. Other researchers have a more precise focus for their study at the outset. For example in the work of Bloor (1978), the focus is clearly stated. Bloor carried out an observational study which includes data from conversations in Ear, Nose and Throat (ENT) Clinics; his primary concern was to establish whether or not geographical differences in the incidence of adenotonsillectomy among children could be attributed to differences in the routine assessments of ENT specialists in different areas. However, as any investigation develops there is always the possibility of a change in direction or an emphasis on the need for more or different data.

The role of theory

Within the debates about qualitative research, there is a sensitivity to theoretical issues, and to the dilemma of having a standpoint, a preoccupation, a theory, which is juxtaposed with a concern and a

commitment to explore subjects' own perceptions of the social world and social reality. Having a theory may introduce premature closure on the issues to be investigated. It is also possible that the theoretical constructs depart from the views of the subjects (Bryman 1988).

A frequently cited approach to the link between theory and investigation is analytic induction, a term coined by Znaniecki (1934), and developed by Robinson (1951). An example of a piece of research which embodies the basic steps in analytic induction is Lindesmith's (1968) study of opiate addiction. The strategy used involved checking the information collected for categories of phenomena and for relationships between such categories. Negative instances, or phenomena that did not fit the initial categories were sought, and throughout the process all cases were explained.

Another approach to establishing the relationship between theory and data is grounded theory. The process was first formulated by Glaser and Strauss (1967). It provides a framework for the qualitative researcher to cope with the complexity of social reality and render it manageable. Bulmer (1991) has questioned whether the researcher is genuinely capable of suspending his or her awareness of relevant theories and concepts until a relatively late stage in the process. There is, therefore some ambivalence about the nature and role of theory among qualitative researchers. Depending on the research at hand, there is the view that qualitative research ought to be more consciously driven by theoretical concerns, while on the other hand there is the belief that theoretical concerns ought to be delayed until a later stage in the research process. Bryman (1988) argues that, apart from the question of whether it is desirable to defer theoretical reflection, the belief that research may be conducted in a theory-neutral way is open to some doubt.

In other words, the qualitative enterprise is not without its critics, both within the perspective and without. The issue of interpretation, and the idea of

looking through the eye of the subject, are not unproblematic practices. The connection between theory and research indicates that analytic induction and grounded theory have provided qualitative researchers with frameworks for attending to theoretical issues.

The emphasis in the present research is on the belief that theoretical concerns must be made explicit in order to provide a framework, while still allowing for some level of analytic induction to take place. This approach to doing research has as its main commitment the 'taking on' of the actor's point of view, or seeing through the eyes of the people being studied. There is an emphasis on description, and a naturalistic approach which retains contact with the real world. It shares with the quantitative perspective the use of comparative method, a commitment to disciplined systematic analysis, and an interest in causation, structures, patterns and frequencies.

By drawing on the evidence from primary and secondary sources, from documents such as Hansard and from newspapers, from the interviewing of contemporary caretakers and the reflections of the researcher, the investigation provides a rich source of data enabling an informed analysis to take place.

The substantive theories on which this work draws come from the conceptual frameworks of power, role, social control and social change. The concept of power facilitates the examination of the relationships between the caretakers and the insane. Issues of power are linked to social control, particularly in the area of the power and social control over the insane which is afforded by the legal establishment through mental health legislation and through medicine by psychiatry. The concepts of role and social change allow for an analysis of caretakers' work when new mental health legislation comes into effect, with consequent social changes. The theoretical and conceptual framework of the thesis is explored in more detail in the next chapter.

CHAPTER 3

THEORETICAL FRAMEWORK

Any attempt at trying to examine the relationship between the caretakers, the insane and social and legislative policy requires theoretical constructs to facilitate systematic analysis. This chapter outlines some appropriate theories, and considers how and what aspects of theory might enable description, evidence-production, analysis and synthesis. The main theoretical approach drawn on is power and social control.

Theory and inquiry are interwoven in a mixture of operations, with theory guiding inquiry, inquiry seeing evidence and evidence affecting theory. According to Kerlinger (1970), theory is a set of interrelated constructs, concepts, definitions and propositions that together present a systematic view of phenomena. Theory gathers together all the isolated and independent parts of information collected into a coherent conceptual framework of wider applicability. Theories organize unsorted facts, laws, concepts, constructs and principles into a meaningful and manageable form. Cohen and Manion (1987) suggest that theory is a potential source of discoveries, new hypotheses and hitherto unasked questions, identifying areas for further investigation. According to Bulmer (1991), the aim of theory is to facilitate the development of analytic schemes; such schemes then become guides to the investigation with the object of seeing whether they or their implications are true.

Power in sociology

The issue of power has occupied a central position in sociological analysis. Using the concept of power to investigate the relationships between caretakers of the insane and their service users is problematic in the light of theoretical debates as to the meaning of power. Two broad approaches to power are drawn on in this investigation; firstly, power as an element of social

action; and, secondly, power as an aspect of social relationships.

a) Power as social action

The work of Weber (1949), particularly his work on bureaucracy, demonstrates that power and domination are constitutive features of social life. Power is the probability that a person in a social relationship will be able to carry out her/his own will in pursuing goals of action despite resistance. Weber's approach to power is linked to his view of domination as the probability that a command will be obeyed. Power has the following characteristics: when exercised by individuals, it includes a choice, agency and intention; it involves an individual achieving or bringing about goals which are desirable; it is exercised over others, and may involve resistance and conflict; there are different interests between the powerful and the powerless; power can be negative, involving restrictions and deprivations for those subjected to deprivations. When the exercise of power is regarded as legitimate, it becomes authority. The Weberian approach emphasizes decision-making in power relationships, but neglects the processes of non decision-making as also a way of exercising power. This failure to act may be considered as evidence of inequalities of power.

b) Power as social relationship

In Marxist sociology, power is regarded as a structural relationship which is independent of the wills of individuals. Power is seen as the consequence of the class structure of societies. Poulantzas (1978) defined power as the capacity of one class to realize its interests in opposition to other classes. In this perspective, power cannot be separated from the mode of production, and it involves class struggle and not just conflicts between individuals.

Power, the sick role, and the caretakers of the insane

Parsons (1967) argues that power is a positive social force which facilitates the achieving of communal ends. Power is diffused through society rather

than being concentrated in a ruling elite. The political system is seen as open and pluralistic, permitting the whole community to participate in the political process. Parsons suggests that power is shared by members of the community.

When applied to particular social situations, this notion becomes problematic. For example, as regards the caretaking of the insane, the need for care suggests an incapacity of the service-users to exercise a full adult social role. Parsons' (1952) concept of a 'sick role' sought to explain the relationship between health care workers, especially doctors, and people who are ill. The doctor-patient relationship is inherently one of power, with power vested in the doctor. The same is true of the caretakers of the insane, as in their role and function they, too, are a part of the medical and care establishment.

Parsons's 'sick role' has four main themes: the sick role legitimates exemption from normal social responsibilities; the sick person needs help and cannot be expected to become well through unaided action; there is an obligation on the sick person to get well; there is an obligation to seek technically competent help and to cooperate with that help in trying to get well. These themes are balanced by obligations, and the role is both temporary and dependent on the sanctions of the wider society. When a person is sick, it is acceptable for her or him not to go to work or attend to family and friendship obligations. This results in a situation whereby, in accepting the 'sick role', power is given to others within the health care establishment to define who is and who is not sick, and who therefore is eligible for a restricted social role.

Following Parsons's analysis, the 'sick role' is socially desirable because it provides an incentive for people to get better, and at the same time limits the pressures associated with the meeting of work, family and social obligations. In these terms the 'sick role' contributes to the equilibrium and stability of society by regulating who can opt out and protecting those who opt out from

being regarded as deviant.

Wolinsky and Wolinsky (1981) argue against the Parsonian conception of the sick role. They contend that Parsons' sick role concept applies only to acute physical health and not to chronic or psychiatric problems; and the concept denies cultural differences, sexism, racism or social inequalities. Access to the 'sick role' is affected by wider issues of social inequality. Wolinsky and Wolinski (1981) suggest that less powerful groups may try to use the 'sick role' to cope with social failure, and in so doing they are required to accept the power of those in authority. Those in authority and with power are likely to be white, male and middle class, while those accepting such power relations are likely to be black, female and poor.

According to this view, the insane are outside the sick role; they are conceived as lacking the capacity to get better and may be defined as deviant. The lack of power on the part of the insane and the exercise of power by others in relation to them results in the insane being contained, and even punished, rather than supported. Both the 'sick role' and the designation of the 'sick role' to particular sections of the community provide the basis of the power exercised by the health care establishment of which caretakers are a part. The caretakers of the insane expect compliance with their directions, and the insane expect to be asked to comply. When the insane refuse to comply with caretakers' instructions, it is likely that the situation arises because they are located on the ambiguous boundary between the 'sick role' and deviance, and because caretakers have to refer to the greater power of the medical profession, that is, the caretaker's work is open to medical scrutiny and control which circumscribes their power. In such situations the power of the caretakers of the insane is grounded in the institutions of law and medicine. Whatever indirect power caretakers may have is also mediated through the institution, the power they have over resources, and the extent to which their knowledge and expertise are recognized by the public.

Wilding (1982) argues that health care workers have considerable control over the deployment of resources within health care organizations. For example, irrespective of the intentions of policy makers, caretakers can determine the ways in which the service actually operates; services may be organized to meet the interests of the caretakers rather than to meet service-users' needs; caretakers may be involved in undermining management. Caretakers also exercise power over the considerable resource of their own time. Examples are: being available to help someone with a physical task such as getting on or off the toilet; providing time to consult and give advice; deciding how much time to spend with any one person, and how it is used; writing reports for doctors and managers which affect the career of the insane person; being an advocate for the insane; and attempting to ensure that practice protects the civil rights of the insane.

The debates around power as an element of social action draw on the work of Lukes (1974). His approach to power involves the consideration of three dimensions: situations where observable decision-making takes place in a context of overt conflict concerning the interest of the individuals or the group; situations when decision-making is hampered because there is covert as well as overt conflict concerning the interest of the individual or the group; and situations in which the agenda is established but there exists covert, overt and latent conflict over both objective and subjective interests of the individual or the group.

It is the third of these dimensions which is most useful analytically, because it enables coercion, influence and authority as forms of power to be examined and explored together. The social nature of power is emphasized, and it is recognized that there is power over others as well as power to act. Hugman (1991) argues that the difference between Lukes' three dimensions can be illustrated with an example from nursing practice, where a nurse administers a drug to a patient. The one-dimensional approach would only apply the

concept of power to an analysis of the nurse's action in situations where the patient refuses to take the drug. The two-dimensional approach would also allow for power being evident through the nurse's actions in avoiding the possibility of an overt refusal by the patient. The three-dimensional approach considers situations in which the patient is in agreement, but such agreement may conflict with her/his objective interests; for example, the patient's understanding of the treatment to be given may be limited, making it difficult for informed consent to be exercised. Here the power of nursing can be seen in the general acceptance by patients of treatments administered by nurses.

There are two important potential implications for the caretakers of the insane in Lukes's three-dimensional approach. Firstly, the individual caretaker or caretakers as a group may exercise power and be unaware of doing so, and may even reject the idea that they exercise power. Secondly, what caretakers do must be examined in terms of relationships within their group, their relationships with other care workers and service-users, the institutions within which they work and the wider social structures and cultural patterns of society.

Lukes's three dimensions generate a framework for theorizing about underlying and unobservable conflicts of interests. What is left unresolved is the question of interests that may lie between the 'objective' and the 'subjective'. A possible resolution to this would be to follow Marcuse's (1964) injunction that individuals cannot recognize their real interests as long as they are subject to distorting dominant ideologies.

Habermas (1977) advances the view that power is often exercised through the manipulation and/or the distortion of communication. Different groups have a different say in the construction of what passes for consensus, and communication may be directed towards the achievement of ends and not towards reaching agreement. An example of this could be where a caretaker

asks a service-user to agree to an intervention; the request here is directed towards achieving professional goals and not to reaching an agreement with the service-user or to give him/her equal status in the relationship. Essentially the caretaker is using his/her power to pursue his/her professional work as prescribed by law, medicine and the relevant professional body.

Power, social divisions and care workers

(a) Social class

Both the control of knowledge by caretakers and their relationships with the insane are connected through class positions and relations. Service-users are more likely than caretakers to be working class (Jones 1983). This is not surprising, given the origins of the caring occupations as a response to the wider social concern with the 'cleaning up' of industrial-capitalist society. Although the care occupations also recruit from the working classes, the social processes of training serve to separate those workers from the working class. Education and training here create a divide in knowledge, skills and values. Dingwall's (1977) study of health visitors' training provides an example of how patterns of speech, dress and behaviour develop in parallel with an ideology of professionalism and a particular model of relationships with clients. Language use communicates class, and reinforces social divisions (Mayer and Timms 1970; Sainsbury 1975; Bernstein 1973). The claim to knowledge by caretakers thus serves to establish an element of their relative class position and adds to the legitimizing of their power.

Caring occupations also exercise ideological power through the production of images and meanings relating to the status and role of service-users. This has consequences both for service-users and for care-workers, as it is a process which serves to establish and sustain the identity of each group. One essential strategy is the production of the categories 'clinical' and 'social'. For example, the insane may be identified as suffering from a particular mental disease or illness which reflects the dominance of medical knowledge. The

insane person becomes a case with a particular mental disease. Such categorizations provide a method for caretakers to structure their thinking and their communication, and one which crucially, as Smith (1980) points out, excludes outsiders, and so helps to determine the nature of the insane person's problems and the kind of response that is seen as appropriate. These structuring categories are routinized and rarely subjected to critical scrutiny; their power rests on their taken-for-grantedness.

Power is also a means whereby care-workers can maintain a physical and social distance from service-users. The strategies used include: the use of separate facilities such as toilets: doors marked 'private' and the formality of interactions (Satyamurti 1981). For example, the use of 'nurse' or 'sister/charge nurse' instead of names is part of a process whereby the anonymity of the care-worker maintains a subtle control in a 'well-mannered' exchange, and the care-worker is enabled both to control interactions and to use interactions for control.

As well as class, ethnicity and gender are significant social divisions affecting the nature of health care and welfare work. There are women and men from different ethnic/racial and gender groups working as doctors, occupational therapists, social workers, psychologists, administrators and nurses. Service-users are also divided by ethnicity and gender. In addressing the power relations between caretakers and service-users, we need, therefore, to consider the extent to which the processes of racism and sexism occur in mental health care work.

(b) Ethnicity and racism

All health care workers share to a greater or lesser extent similar theoretical frameworks, and they may use these in their interactions with ethnically different service users. Any criticism of psychiatry is also relevant to other health care workers involved in the mental health services. Some psychiatrists

have identified racism in mental health services. Culture and ethnicity as social statuses and as stereotypes affect diagnosis, treatment and care (Littlewood and Lipsedge 1988; Rack 1982). Health professionals, including the caretakers of the insane, may fall into the trap of dealing with racism by thinking that all that is needed to make a non-racist care worker is cultural knowledge. But this type of debased psychiatric anthropology may only mean that care-workers falls back on racist cultural stereotypes (Mercer 1986).

Hugman (1991) offers three explanations for racism in the mental health services: the experience of migration to a new culture may be too stressful; aspects of black people's life experiences, for example racism in white society, may contribute to mental illness; psychiatric practices are racist because they are ethnocentric. Each of these views is central to psychiatric practice, including the work of the caretakers of the insane.

While migration may exact a psychological toll, this explanation cannot be taken out of the context of racism more broadly. Littlewood and Lipsedge (1988) point to the potentially destructive effects of adjustment to a new culture on personality, resulting in mental ill-health as the price of adaptation to a society which only accepts the migrant on racist terms. Most black people in the United Kingdom are not immigrant, yet the incidence of mental ill health appears to be high amongst black people whether migrant or not (Torkington 1983). This suggests that there are common features of the social position of black people which may precipitate psychological crisis. However, as Brittan and Maynard (1984) point out, the capacity of black people to resist is largely ignored. Resistance exists, and it often takes the form of asserting those aspects of black culture which white society devalues. This can result in confrontations which may lead to psychiatric diagnosis and treatment; and psychiatry is supported by a relationship with coercive state agencies such as the police. Mercer (1986) argues that it is this process which is behind the

over-representation of black people diagnosed as mentally ill. The black person's resistance is interpreted as bizarre and deviant by the dominant white culture. The psychiatric diagnosis rests not in the lack of awareness of black cultural forms, but in the power of white psychiatry to impose ethnocentric concepts on the experience of black people. The issue here is not that black people do not experience mental distress, but that there are complex factors involved.

(c) Gender and sexism

Interwoven with racism is the gender dimension. Gender refers to the social construction of femininity and masculinity based on ascribed sex differences (Oakley 1972). Gender segregation occurs within the caring occupations; there is a tendency for specific types of work to be undertaken by women and others by men. For example, in social work practice women are more likely than men to work with the elderly, while men are more likely to work with mental health or child care (Howe 1986). This situation is similar in nursing where there is a sharp gender division between general and psychiatric nursing. The places in the caring occupations occupied by men have been associated more with control than care. This is seen in the male dominance in work with offenders and in asylum work (Carpenter 1980).

The service-users of the caring occupations are predominantly women (Dominelli and McLeod 1989). According to analyses such as that provided by Hugman (1991), the experience of being a service-user is structured by patriarchy. This has implications for the provision of services and the relationships between service-users and care-workers at both the individual and the collective levels. The operation of patriarchy is clearly seen in the work of psychologists who fail to address the issues pertaining to gender (Mitchell 1974). As Broverman *et al.* (1970) argue, the higher incidence of women diagnosed as having mental health problems can be explained as a consequence of the social construction of women's lives, and the problems

associated with the domestic role, where social definitions of motherhood play a key role in restricting and devaluing women (Brown and Harris 1978).

These arguments and critiques have had only a partial impact on the work of caretakers. Care relationships, argues Goldie (1977), parallel aspects of marriage; the passive women patient comes to rely on the active man as therapist for acceptance and approval. This can be applied to the work of caretakers, where the control of treatment and therapy is in the hands of mostly male psychiatrists supported by mainly female caretakers. Male and female caretakers who attempt to work against this may find themselves confronted by arguments formed to preserve the patriarchal status quo. Because psychiatric theories are implicitly or explicitly gendered, caretakers may be faced with a choice between complicity, confrontation and covert opposition.

This analysis points to power as an inherent and often covert aspect of the work of caretakers. Caretakers may find it difficult to confirm that they do exercise power in their relations with service-users, because in making this explicit they would be challenging the institutions and organizations concerned with the care of the insane.

Social control

The concept of social control refers to something that happens in the social world of which people may or not be aware. Whenever the terms 'persuade', 'restrain', 'discipline', 'coerce', 'direct', 'manage' or 'regulate' are used to describe the activities of individuals, groups or organizations, the exercise of social control over people's minds and bodies is relevant.

Social control may be direct and overt or indirect and covert. In some instances, overt and covert social control go hand in hand; for example, within schools, families and health care facilities. Society as a whole is

governed by a complex system of legal statutes and other law-enforcing mechanisms which regulate behaviour in a wide range of areas. Social processes in general may have a control element which is intended or unintended, recognized or unrecognized by the parties concerned. For example, in the course of working with the insane, doctors and caretakers may influence service-users' lives through shaping their attitudes, beliefs and actions, and in either reinforcing existing patterns or in others changing them (Edwards 1988).

Social control is related to the concepts of authority, law and order and morality. The implication here is that people need regulation and restraint. For Marx, Durkheim, Weber and other major social theorists, social order and social control are essential analytic concepts in reaching an understanding of how societies achieve and maintain social order. There are different approaches to the problem of social order, and different conceptions of what social control is and what it does (Watkins 1975). Edwards (1988) argues that the differing perspectives have certain common underlying assumptions about social order and social control. The following assumptions, Edwards suggests, are common: that social control is an essential and desirable function on which the survival of society depends; that social control involves the use of mechanisms, techniques and strategies to discourage, restrict, or prevent behaviour which constitutes a threat to the majority; that the responses of social control agents such as doctors and caretakers are justified when individuals exhibit disruptive, disturbing, dangerous or deviant behaviours; and that specific activities and processes of social control belong to certain categories of people and to special institutions. The examples here are the police, magistrates, psychiatrists, caretakers, social workers and teachers. All these workers may contribute to the social control of the insane. The principal social control institutions here are the mental health system and the legal-judicial system.

A critique of Edwards' view is offered by Matza (1969), who contends that it accepts too unquestioningly the need for social control. Of relevance here is the analysis of social control offered by functionalists, labelling theorists, Marxists and feminists. The functionalist approach is exemplified in the work of Parsons (1951). Parsons argued that social control is universally present in all societies. Social control is a 'normal' social phenomenon serving the interests of the community. Within societies there are pressures and tensions, and social control is necessary to contain and counteract such situations. Medicine is a major social control system and the main alternative to law and criminal justice in the modern world. Parsons describes both illness and crimes as having common and different characteristics. A different characteristic is that the sick role confers a **conditional** legitimacy while crime is regarded as **illegitimate**. This results in the person deemed to be sick being subjected to reintegrative processes, while the criminal experiences exclusion. In the services offered to the insane we can see that there is both a criminal and an illness element; such individuals may be placed in a confusing situation where they experience the integrative processes of the medical system and the exclusionary effects of the criminal justice system. According to Orcutt (1983), Parsons worked with a medical model of a self-regulating and self-maintaining social system, where the problem of social order is solved by referring to the existence of an underlying normative order of shared moral and social values, which is prior to, and independent of, the social relationships within a given society. The integration of the various parts of the social system therefore rests in value consensus.

Functionalism does not deal effectively with questions about sources or causes of particular modes of social control. It deals poorly with questions concerned with who is subject to social control, on whose behalf it is exercised, with what purposes and interests, and how social control mechanisms are linked to the political structure and power relations within societies. Pfohl (1985) argues that both Parsons' social system model and the

functionalist mode of analysis are problematic. In these approaches, social control is viewed as taking place in a social world which is unproblematic, homogenous, stable, deterministic and based on a moral consensus. Conflict is relegated to the periphery, where social control is exercised by agents enjoying full authority and official legitimacy. Perhaps all functionalism can usefully say about social control is that it may indeed be a universal aspect of all human groups and societies, and it may be related in complex ways to other aspects of social order.

Since the 1960s, the application of labelling theories to the study of social control has extended the debate on concepts of social control. The diverse contributors to this perspective approach social control by seeing it as part of the broader social construction of insanity, deviance and criminality. It is involved in rule-making, norm-defining and standard-setting as to what is socially appropriate; it contributes to the fixing of labels and to the creation and implementation of various types of sanctioning.

Labelling theorists see social reality as a construction created by human action and consciousness (Edwards 1988). Integration, cohesion and consensus are not taken for granted but are regarded as historically variable aspects of the social order. Society is seen as characterized by pluralism, diversity and competing ideas and interests. This perspective is vulnerable to the accusation that it offers only a micro or social psychological account of social control, and runs the risk of lapsing into relativism (Davis 1975; Taylor *et al.* 1973). Another criticism is that this perspective lacks an adequate theory of structure, power and ideology.

By contrast, Marxists look behind these phenomena to uncover what they believe to be fundamental structures and processes - the forces and relations of production. In classic Marxism, society is divided into groups with unequal access to the means of production. This gives rise to a social structure

characterized by conflict and struggle in which the dominant groups have to employ coercion, regulation and repression to maintain their control over the productive system and over subordinate groups. The problem of social order is seen as being a product of historical conditions and social practices. These conditions and practices create and maintain social inequality and exploitation, along with the imposed order which is necessary to safeguard the beneficiaries of the system from attacks by the oppressed majority.

The State and social action

Jessop (1978) argues that the modern capitalist state is the principal institutional locus of power. The state operates in a number of arenas - economic, political, socio-cultural and ideological - and through a range of agencies, both public and private. The state employs a number of strategies, including legitimation and regulation. An important distinction between two major social control approaches - the repressive and the ideological - is made by theorists such as Gramsci (1971), Althusser (1971) and Poulantzas (1973). Both the repressive and the ideological dimensions of social control are present in institutions and are operations of the modern state, which accordingly regulates and manages all sectors of society. Common to all such institutional regulation are the processes of bureaucratization, professionalization and the application of scientific knowledge and technology. The provision of welfare is part of the State's control process; the negative image of capitalism is offset by a demonstration of the benevolent side of capitalism and state regulation. Gough (1979) sees the modern state as embodying tendencies to enhance social welfare, and to develop the powers of individuals, as well as instituting mechanisms through welfare institutions such as education and health for repressing and controlling people.

Gender, the state and social control

In a class-divided society both women and men are subjected to material and

ideological forms of social control. Men and women are affected differently. Women are principally controlled within the private domain, where they are subordinate to men economically and legally. This control extends to other areas which are experienced only by women; the reproductive cycle; a subordinate social and legal status in relation to men in the family; the separation of home and work; and the ideology of the woman's place (Smart and Smart 1978). According to Mitchell (1971), the oppression of women is due to the social structures concerned with production, reproduction, sexuality and the socialization of children. As Klein (1981) observes, sexism results in economic exploitation, political domination and psychological oppression. In a radical feminist analysis, many institutions and organizations of social control form part of the state patriarchy. The institutions and organizations of importance here are the judiciary, the welfare system and medicine; these all reinforce social divisions and inequalities.

Feminist critiques in this field have argued that established academic disciplines, such as sociology, criminology and psychiatry, have relied on sexist stereotypes of women. In such stereotyping, women are characterized as irrational, immature, suggestible and governed by their biological-sexual nature (Edwards 1988). But these institutionalized perceptions themselves operate as social control systems. When women are seeking medical or psychiatric care, welfare benefits or legal assistance, their problems are likely to be trivialized, individualized and attributed to their own inadequacies, and both the role of men and that of socio-economic circumstances are likely to be played down.

Power and social control

Like Marxist labelling theorists and feminists, Foucault regards power as central to any analysis of social control. Starting with the construction of the modern concept of madness, moving on through medicine to the prison system, Foucault offers us insights into the development of discourses, that

is, techniques and ideologies for the management of human beings (Foucault 1967, 1976, 1977). This discipline, as he calls it, operates through the control of minds, wills and behaviours. The people subjected to these techniques and ideologies are regarded in the same way as machines, that is, to be made as efficient and useful as possible. Power is seen as positive and productive, not a thing to be possessed, but exercised through particular techniques and strategies. For Foucault any analysis of power starts at the micro level and works upwards; his analysis denies the existence of any structural economic or political determinants of power.

Social control and the health care system

The case for treating medicine as a major institution of social control is made by Zola (1972), Freidson (1970) and others. Freidson argues that medicine functions as a formal, official instrument of control. With responsibility for regulating the entry into, conduct in, and exit from the sick role, it has a crucial function in the management of illness and disability. Medicine's operation as a control mechanism has been concealed because of its characteristics as a 'science' offering clinical treatments. In this perspective, the medical model is a social construction, a dominant social control paradigm, and a mode for understanding human behaviour and the natural and social worlds. Theorists such as Freidson (1970) and Conrad and Schneider (1980) see medicine as the most powerful institution of social control apart from the legal system itself. More and more problems of human and social behaviour are regarded as requiring medical and therapeutic intervention. This therapeutic control philosophy is generally welcomed as a sign of a socially progressive and civilized society. With the increase in medicalization, 'undesirable' aspects of the human condition are increasingly being treated as caused by biological, psychological or environmental factors. In order to achieve this ideological objective, medicine employs metaphors of illness or sickness and a theory about causes and remedies which purports to rest on the 'objective' basis of 'science'.

Social control and the mental health services

The mental health services are an area where the appropriateness of mediating social relations by legal forms has been hotly debated. Central to the legal aspects of mental health care delivery are the people who wish to subject the psychiatrist and all other mental health workers to a tight regime of legal rules. These rules define the relationship between service-users and service-providers in terms of rights and duties. There are those who see such rules as imposing a legal straightjacket on the discretionary nature of the therapeutic processes of psychiatric care. There are also those who view service-users and service-providers as being polarized by conflicting interests and power relations. The most extreme illustration of this is the compulsory admission of service-users. For this reason, service-users need legal rights in order to defend their civil liberty.

It can be argued that the law actually constitutes the mental health system. It constructs, empowers and regulates the relationships between providers and users of mental health services. In so doing, the law preconditions the social control functions of psychiatry through surveillance and discipline; without the law the system would not function in its present state. The law determines relevant skills and qualifications and the division of labour between service-providers. Furthermore, the law fulfills an important function as an agency of social control in inhibiting and restraining psychiatric power in the interest of civil liberties and the accountability of the psychiatric services. The law also legitimates the psychiatric services, and enables psychiatrists to distance themselves from the coercive operations of the system. This is evident when powers and decisions concerning hospitalization are shifted towards members of service-users' families, social workers, magistrates, and mental health review tribunals and/or multidisciplinary panels. Unsworth (1987) argues that all of this helps to medicalize the psychiatrist's image as a healer rather than a gaoler.

In the mental health services, two social control disciplines come together, namely the legal-judicial and the medical. The legal-judicial system is widely regarded as the main regulatory mechanism of the state. Both the psychiatric and the legal-judicial systems are agents of social control and, as such they are essentially political activities (Heather 1976). The area of law which deals with compulsory treatment is unarguably a means of social control. Moreover, it strengthens the social control of psychiatry by ensuring that psychiatry can do its social control job through using legitimized force. According to Langman (1980), the legal judicial system colludes with psychiatry to enforce the moral codes which legitimate the social order. The status and power of the psychiatric system are thus maintained. The mental health law allows for the formal enforcement of the sick role and ultimately the psychiatrist's orders.

Mental health law, which is civil law, overlaps with criminal law. The criminal justice system usually has more stringent procedural safeguards to prevent wrongful deprivation of liberty. It may therefore be seen as quicker and cheaper to involve mental health law rather than criminal law in some cases. Should this situation occur then the individual's rights would have been ignored. Criminal law centres on provable and defined offenses; these considerations are rarely important in mental health law. What this means, according to Cavadino (1987), is that there may be a tendency and a temptation to use psychiatric law as a means of social control in circumstances where morally and politically it would be more desirable to use the criminal justice system.

The 1960s and 1970s saw a rise in critiques of medico-legal social control in the mental health services (Cavadino 1987). The critiques of authors such as Laing (1959,1967), Cooper (1967), Szasz (1971,1972,1974), Scheff (1966), Goffman (1968) and Foucault (1967) offered a powerful indictment of traditional psychiatric attitudes. The 'anti-psychiatry' movement seemed to be

saying, keep people away from the mental health services. Szasz claimed that mental illness was a myth, and that there should be no such thing as mental health law. Laing suggested that the mad might be saner than the rest of us, that their madness was an understandable response to oppression, and that to medicalize it by calling it mental illness was to add to this oppression. Scheff argued that labelling people as mentally ill was what caused mental illness. Goffman saw psychiatric institutions as inherently inhumane. According to Foucault, labelling of people as mad is closely linked to the social relations of capitalism.

The delivery of a public service requires distinctions to be made between individuals so that their needs can be met. However, the mental health services tend to function through diagnostic labels which gives the impression that the mentally ill are a uniform group. Such a situation maintains the social control of people deemed to be mentally ill, and so could perpetuate the infringement of their rights. While the law through mental health legislations provides a framework for the provision of services, civil liberty organisations, The National Association for Mental Health (MIND) and user groups, are asking for the safeguard of the rights of users through: the right to have appropriate care, treatment and rehabilitation in a humane environment; the right to care and treatment in the least restrictive environment; the right to decide whether to consent to treatment or have a second opinion; the right to retain normal civil rights and social opportunities; and the right of appeal, regular review and representation when restrictions are being considered or imposed.

Social control is both a sociological concept and a social phenomenon. Attention has to be given to changing definitions, perspectives, approaches, institutions and processes, when control over people is exercised. Social control is closely related to other concepts, including discipline, authority, law and order and morality. In the twentieth century, medicine has expanded as

an institution of social control. The legal-judicial system, the psychiatric system and the providers of psychiatric and mental health services all share in the social control of the insane.

CHAPTER 4

INSANITY, MADNESS OR MENTAL ILLNESS?

As the last chapter demonstrated, psychiatry has come under sustained criticism recently as that branch of medicine which provides for the medical and legal control of the insane, the mad or the mentally ill. Much of this criticism is articulated through the language of rights, liberties and justice. This chapter looks at aspects of psychiatry which may be considered as violating or ignoring the rights of individuals. It explores the nature of insanity, critiques of the medical model, and the relevance of the user perspective.

Defining insanity

A varying number of people in Britain are likely at sometime in their lives to enter a state of acute or severe emotional or psychic disturbance in which they are unable to cope with everyday life. They might identify a need for help themselves, or they may be identified by others such as work colleagues, friends or relatives as being either at risk of harming themselves or of harming others. Their behaviour may be considered so disturbing that they have to be removed from their usual social setting. Such removal is usually to the care of psychiatrists, who may employ a medical model of care and treatment (Lindow 1990).

Today there is no general agreement as to the nature of insanity, that is, what it is, what causes it, and what will cure it. There are conflicting opinions about insanity, and among psychiatrists there is hardly a body of knowledge on which all agree. The concept of mental illness is beset by debates and interpretations. Is it a label for rule-breaking and socially unacceptable behaviour? Is it a concept which misleads with its medical connotations by suggesting that distorted interpersonal relationships amount to mental sickness? Is it a political expedient enabling those who hold power within society to devalue dissenters and violate their freedom? Or is it a concept

which is analogous to physical illness and applicable to those who manifest, not physical pathology, but a psychopathology which impairs judgement and personal responsibility? Given the debates which rage it is hardly surprising that people are variously referred to as 'insane', 'mad', 'lunatic', 'mentally ill', 'deviant' and 'socially disturbed', and the professionals working with such persons refer to them as 'patient', 'client', 'deviant', 'dissident', 'consumer' or 'service-user'. There is also confusion over the criteria used to diagnose people as mentally ill.

Insanity has a long tradition. Since biblical times there have been records of people who seemed 'odd', who said they could hear voices or see things which no one else present could hear or see. At various times such people have been regarded as witches, wizards, warlocks, saints or persons possessed by the devil. According to Rosen (1968), some such people were accorded prestige as oracles and prophets, but more commonly they were called insane and were subjected to abuse, scorn, or ridicule. The insane have commonly been deprived of rights. For example, under Roman Law they could not marry or dispose of property. In the Middle Ages they were believed to be witches and wizards who possessed evil spirits, and the priests were turned to, to exorcize the evil spirits. They were also subjected to ceremonies of ritual purgation, demon expulsion, herbal baths and other physical and surgical treatments. In contemporary society parallel care, treatment and cure activities are still used within psychiatry.

Porter (1987) argues that insanity has remained an elusive state. He asks, is insanity truly a 'disease' rather in the way that we all accept that measles is? Or might it not be better regarded essentially as a badge we pin on people displaying a rather subjectively defined bundle of symptoms and traits, but who at bottom are just mildly or severely 'different' or 'odd'? If this is the case, is the bottom line simply that we call people mentally 'confused' because we find them 'confusing' or 'disturbed', and essentially because we find them

'disturbing'? The 'mad' are strange. But does that mean anything more than to say that they are strange to us? And then what about the fact that we are strange to them? (Porter 1987:8-9).

Hunter and McAlpine (1974) argue that psychiatry is foremost a branch of medicine and subject to its discipline, and that mental illness is not somehow different from physical illness (as terms like 'neurosis', 'psychosis' and their subdivisions might imply). They contend that patients suffer from mental symptoms which are caused by disease in just the same way as bodily symptoms, and that it is the psychiatrist's task to identify the cause and nature of these using the methods of modern investigative and laboratory medicine. This argument attributes little importance to the social context within which insanity develops; social conditions are seen as having only an incidental effect. The approach assumes there is such a thing as mental illness which exists objectively. But not even physical illness is like this, because both cultural and historical definitions vary.

All societies have systems for coping with people whose behaviour is different, disruptive or dangerous. But the ways in which such forms of behaviours are described, judged and managed differ from society to society and from era to era. The language, ideas and associations surrounding insanity do not have fixed scientific meanings. What insanity, madness, mental illness, physical illness and badness are is not fixed; these terms have social, physical and cultural bases which are deeply contested. For example, in the UK, relatively mild mental and emotional incapacity is commonly called 'neurosis', which is regarded as 'functional', a product of worry or stress rather than 'organic', and may be treated by the psychiatrist. The opposite is true in China, where comparable disabilities are regarded as a 'neurasthenia' - a disease of the body itself. This diagnosis of neurasthenia was once common in the UK but is now extinct here. Such contrasting diagnoses and treatments follow from divergent socio-cultural priorities. In the individualistic UK, mental

disorder, if mild, is regarded as relatively legitimate. We have a right to complain when we are miserable, and to seek redress.

Szasz (1971, 1974) has argued that psychiatry has one overall function which is to control behaviour. Moral views are translated into medical terms, and the making of such terms is powerful in the regulation of behaviour. He argued that medicine, and particularly psychiatry, is the means whereby the dominant values of society are disseminated. Szasz supports his views by citing the rules of admission of the French asylums. These rules state clearly that the categories of persons to be admitted are the young, who disobeyed their parents, those who refuse to work, unmarried women and various other 'miscreants' and 'indigents' who could not be dealt with elsewhere. Another example which Szasz (1979) cites is the illness termed 'negritude' which was discovered and articulated by Benjamine Rush, an American psychiatrist (1745-1813). Rush observed an African American, Henry Moss, who suffered from 'vitiligo,' a skin disease in which white spots appeared on the skin. Rush then argued that all African Americans suffered from a mild form of congenital leprosy which was hereditary but not contagious. Therefore African Americans were safe as domestic servants, but not as sexual partners. This label of 'negritude' provided, according to Szasz, the perfect diagnosis, as it upheld the status quo and expanded the power of medicine and psychiatry.

The development of facilities for the insane

Before the reform movements of the early nineteenth century, there was general state responsibility for lunacy (Scull 1974). With the reform movements came a series of parliamentary reports and recommendations which resulted in the building of the county asylums. Scull explains this change in policy towards the insane as being due to industrialization and urbanization. Families were no longer willing, or able, to look after their disturbed members, so the development of institutions provided a solution. Scull's argument is that economic considerations were largely responsible for

the development and growth of county asylums. However, it can be argued that this is not a sufficiently broad explanation, as economic necessity cannot by itself account for changes in public health policy. There are a great many factors which have contributed to changes in the condition of the insane in the nineteenth century and in contemporary Britain.

The state was concerned about the insane, and provided institutional care throughout the eighteenth century (Parry-Jones 1972). There were private madhouses for private patients and pauper lunatics. In other words, institutional care for the insane existed long before the processes of industrialization and urbanization. Another factor which contributed to the concern with the insane was the illness of George the 111 between 1782 and 1820. Public sympathy was alerted to the King's plight and Parliamentary inquiries on the condition of the insane were set up in 1788 and 1790 and heralded some lunacy reforms. All these situations, plus the theory of moral management and a general optimism about cures for insanity, affected the general public's concern for institutions to provide care.

In his book **Madness and Civilization**, Foucault (1971) traces attitudes to madness from the Middle Ages onwards. He asked, why was madness set apart and feared? His argument is that the treatment of madness in any age is primarily an expression of fear and an attempt either to banish, control or cure it. At the beginning of the nineteenth century the plight of the insane was compounded by the fear that they might contaminate other people. With this in mind, 'moral managers' were encouraged. Such people should not, argues Foucault, be credited with having liberated the insane; rather they instituted a more complete, and more psychological form of control.

Who is insane, mad or mentally ill?

There is much debate around the notion of illness being attributed to the people who are considered to be insane, mad or mentally ill. Attributing

illness to people whose behaviour is different is confusing because illness has more than one meaning. Freidson (1973) has argued that a distinction can be made between illness as a bio-physical state and illness as a social state. The former refers to abnormalities in biological functioning, while the latter is bound up with people's beliefs, evaluations and actions. While Freidson concentrates on these two meanings of illness, it must be noted that a strong approach in psychiatry is to consider the effects of the soma - the physical - and the psyche - the psychology - of the individual experiencing illness.

Illness as a social state is a deviation from normality. Norms and deviations from them are socially and culturally constructed, in the sense that particular societies at different times reach different kinds of general agreement about what constitutes health and ill-health. This social analysis of illness provides one of the main critiques of the medical model of insanity. Scheff's (1966) propositions about mental illness build on the theoretical perspective known as labelling theory; he argues that the behaviour exhibited by the person deemed to be mentally ill is essentially rule-breaking behaviour - behaviour which goes against agreed social rules. This rule-breaking behaviour can arise from a variety of sources: organic, psychological stress, external stress or acts of defiance, rebellion or innovation. Scheff points out that much rule-breaking goes unacknowledged. In many ways the important question is why some rule-breakers, but not others, become identified as mentally ill. Scheff suggests that most rule-breaking is denied by social groups; the social group accepts that members may go through a bad phase, that some people are eccentric or behave in idiosyncratic ways, and that the rule-breaking is transitory. But in some cases there is the opposite social reaction; the breaking of rules is magnified and individuals are labelled as mentally ill by their families, doctors and social agencies; once the individual is so labelled a certain 'mad' behaviour is expected from the person. A person labelled as mentally ill will be rewarded by others for accepting the label and playing the

ascribed role; if everybody tells you that you are mad you come to accept it, especially if the label comes from a person of authority and influence such as a judge or a psychiatrist.

Scheff's model of applying the labelling theory of deviance to mental illness amounts to the argument that the act of labelling someone as mentally ill is what creates the mentally ill behaviour. Without the labelling process, the original behaviours would have gone unnoticed. Scheff supports his propositions from research data. He studied patterns of admissions and discharges in three state hospitals in a Midwestern state of the USA in 1962. He concluded that psychiatrists applied diagnostic categories without undertaking detailed medical examinations, and so in this sense were acting principally as agents of social and legal control. The implication here is that the rule-breakers brought to the attention of psychiatrists behaviours that were widespread in the population, and that these behaviours were used as a pretext for labelling people as mentally ill. Many patients were suffering from nothing more than labelling. Support for this view comes from Goffman (1961), in his analysis of the 'moral career' of the mental patient. Goffman argues that such individuals suffer from the hazards of labelling by reference groups and professionals. Scheff's argument is also supported by a study by (Rosenhan 1973). In Rosenhan's study, nine people (mostly professionals and academics) behaved as pseudo-patients by presenting themselves to a hospital admission department complaining of hearing voices. Once admitted, they ceased to simulate abnormal behaviours and told the psychiatric staff that they did not need treatment. However, eight were diagnosed as schizophrenic and one as manic depressive; they were hospitalized for an average stay of 19 days. During their stay, they experienced their requests being ignored and being treated as incompetent and insane. This experiment shows that labelling is a powerful force in social relations.

There are other views about the nature of mental illness according to which there is some mental disturbance which does exist apart from the social labelling process (Grove 1970). Coulter (1973) questions Scheff's assumption that people who believe bizarre things and act in 'odd' ways are not genuinely insane, and that such individuals internalize without question the imputation of mental derangement. Coulter argues that if this were the case mental hospitals would be populated by frauds. Another critic of Scheff, Wing (1973), points out that it would be difficult for societal reaction alone to cause a person to adopt, for example, the behaviours of a schizophrenic; this would need special coaching from an expert.

Within the anti-psychiatry movement, mental illness is regarded as a label which obscures the cries of the downtrodden and exploited against an alienating and dehumanizing society. Psychiatric intervention is seen as a social control arm of the dominant political order and an agent of repression and of power. The anti-psychiatrists demand the abolition of existing psychiatric institutions and insist that psychiatrists either acknowledge their role as society's thought police or become agents of social change. As commentators such as Miles (1987) and Sedgwick (1973) have pointed out, the anti-psychiatrists have raised the public consciousness about the complex social meanings underlying the classification of someone as mentally ill; in other societies, or under different circumstances, such behaviours would be likely to be interpreted differently. Miles has further argued that the anti-psychiatry movement has attacked the 'illness' approach to mental illness and the practice of psychiatry, and in so doing it has put forward a conspiracy approach in which all psychiatrists and mental hospital personnel are seen as agents of an oppressive society with doubtful motives and methods of treatment.

The user perspective

Rogers *et al.* (1993) argue that whilst Goffman, and the followers of Szasz and

Laing, provide humanistic critiques of traditional psychiatry, they ignore in their accounts patients' perspective on their experiences and patients' collective voice. Compared to physical health and illness, mental health service-users have received considerably less attention from sociologists and researchers (Rogers and Pilgrim 1993).

The involvement of people who use the mental health services has gathered momentum in the last twenty years, mainly as a result of their dissatisfaction with the service. Users of the psychiatric services are now involved in the self-advocacy movement. Examples of these organizations in the UK are: Survivors Speak Out, Mindlink, Mind User Network and the United Kingdom Advocacy Network. Apart from giving users a platform to discuss their experiences of psychiatric care and treatment, these organizations can influence policy through their representation on national bodies. For example, user groups are represented on the Mental Health Task Force, the Mental Health Nursing review Board, the Audit Commission, The Department of Health's Community Care Support Force and the Mental Health Foundation. However, these organizations have little funding, and often feel tokenized and exploited by service providers. Some groups, such as the Brent User Group and the Afro-Caribbean Mental Health Association, also run a drop-in service for the local community.

Butler (1985) has pointed out that the organized patient voice today is relatively weak. Documentary evidence of individual patients' voices can be found in literature. For example, John Perceval was confined to two different private madhouses between 1831 and 1834. In 1835 he began writing about his experiences as a patient. He described his visions and delusions, and what they caused him to do; he describes his treatment in terms which are remarkably similar to those heard in the current self-advocacy movement today:

'Now with regard to my treatment, I have to make a first two general observations, which apply, I am afraid, too extensively to every system of management yet employed towards persons in my condition.

First, the suspicion and the fact of my being incapable of reasoning correctly, or deranged in understanding, justified apparently every person who came near me, in dealing with me also in a manner contrary to nature...

Secondly, my being likely to attack the rights of others gave these individuals license, in every respect, to trample upon mine... Instead of my understanding being addressed and enlightened, and of my path being made as clear and plain as possible, in consideration of my confusion, I was committed, in really difficult and mysterious circumstances, calculated of themselves to confound my mind, even if in a sane state, to unknown and untried hands; and I was placed amongst strangers, without introduction, explanation or exhortation.

Instead of great scrupulousness being observed in depriving me of any liberty or privilege... in every dispute, in every argument, the assumed premise immediately acted upon was, that I was to yield, my desires were to be set aside, my few remaining privileges to be infringed upon for the convenience of others... Against this system of downright oppression enforced with sycophantish adulation and affected pity by the doctor, adopted blindly by the credulity of relations, and submitted to by the patients with meek stupidity, or vainly resisted by natural but hopeless violence, I had to fight my way for two years... I did not find the respect paid usually even to a child' . (Peterson 1982:105-107).

Users of the mental health services are asking for more humanity, respect, listening, counselling, therapy and alternatives to medication. They seek more information, more choice as to treatment, improved and more equal relationships with care providers, protection of their civil rights, the availability of a safe place when in crisis, and services which respect differences of gender, ethnicity and personality.

The users' agenda may conflict in some areas with providers' sense of doing their best within limited resources. The provisions of the medical model with its emphasis on emotional distance, objectivity, physio-chemical solutions to social and psychological problems and the central power role of the psychiatrist, are regarded by some users as obstructing effective care and treatment. While accepting that medical science and psychiatry can and do provide help, treatment and care for those experiencing both mental illness and problems of living, there is a need for professionals providing psychiatric services to accept that their social control functions may be overriding their caring functions.

Who then is mad, insane or mentally ill? Different writers and researchers would answer this question in different ways, some argue that no one is, because madness, insanity or mental illness does not exist; others say that if the disease theory can be applied then the individual can be considered as being mad, insane or mentally ill. Perhaps what is needed are questions about how users get into situations of being regarded or regarding themselves as insane and what are the types of behaviours which lead the public to conclude that someone is mentally ill, and what actions are taken by the public in respect of such problems?

CHAPTER 5

MADNESS AND SOCIAL DIVISIONS

This chapter discusses the issues, questions and debates relevant to psychiatry and the social divisions of class, gender and ethnicity (with particular emphasis on African Caribbeans). While it can be argued that medicine and psychiatry do contribute to healing and wellbeing, health professionals are increasingly being asked to attend to critiques of their practices vis-a-vis poor people, women and those belonging to ethnic minority groups.

Social class and insanity

Skultans (1979) has argued that in the eighteenth century the diagnosis of the 'spleen' or 'vapours' was a mark of distinction, and 'hysteria' was the mark of a lady who lived a life of grandeur and idleness. Szasz's work recognizes the social dimension of insanity and the complex relationships existing between social values and psychiatry. He points to psychiatry as the protector of the rich and the well educated, and as the oppressor of the poor and the socially disadvantaged.

There is a large amount of evidence suggesting that the poor are over-represented in diagnoses of insanity. In a report on insanity in Massachusetts, Jarvis argued in 1855 that the poor contributed proportionately 64 times as many cases of insanity as other classes. Faris and Dunham (1939) came to a similar conclusion in their report in Chicago. They showed that the areas having the highest mental hospital admission rates were those with the greatest number of people in the lowest socio-economic groups. Hollingshead and Redlich (1958) came to similar conclusions. They also found that the association between identified mental illness and social class held whether measured in terms of prevalence (the number of cases in treatment) or incidence (the number of new cases coming into treatment).

Miles (1981) has argued that the relationship between rates of mental illness and social class is mediated by the social processes by which people become defined as mentally ill. People from the lower end of the social scale are the most likely to become defined as mentally ill and encounter most difficulty in returning to normal social roles. It can be argued that, given psychiatric problems of equal severity, people from poor backgrounds are more likely than those in better circumstances to be admitted to a mental hospital. At the same time, labelling theorists argue that the psychiatric label, like other stigmatising labels, is most likely to be applied to those who are powerless to resist it. Therefore, the concentration of mental illness in the lower classes may be in large part a consequence of the greater chance of such people becoming defined as mentally ill. Hollingshead and Redlich (1968) found that psychotherapy and psychoanalysis were given almost exclusively to middle class patients. Psychiatrists tended to choose higher class, well-educated people for this treatment, assuming that lower class people lack the aptitude to participate effectively.

In the UK today, the National Health Service, although theoretically equally available to all, is accessed more effectively by the middle classes because they are more informed, have more contacts and demand better services. They are also able to pay for private care and treatment and so avoid treatment in NHS mental hospitals. There are many reasons why the association between lower socio-economic class and treated mental illness may be over-emphasized: for example, some middle class people with psychiatric problems may receive help, but still not appear in official statistics; lower class patients may stay longer in hospital because psychiatric staff are more willing to discharge patients to comfortable than to materially deprived homes (Miles 1987).

Gender

The disadvantageous situation of women in terms of social contacts, prestige

and power has been well-researched. It has been argued that modern industrial societies impose great stresses on women and that consequently their problems in living have been translated into mental illnesses. This is seen in women's higher rates of mental disorders, and in particular depressive disorders. According to the critiques developed by Miles (1987), Usher (1991), Russell (1995), and Showalter (1987), the psychiatric services are contributing to the oppression experienced by women in our patriarchal society. Within the area of mental disorders, Miles (1991) has argued that women are literally driven mad by oppressive social structures, and that they are more likely to be labelled neurotic or mad by professionals and lay people, due to the widely held stereotype of the neurotic complaining woman, and because of women's lack of power to reject the application of such labels.

Women throughout history have been shut up in madhouses as well as royal towers by their fathers and husbands (see Figure 1). Feminist interest in female insanity has now gone beyond artists and writers and beyond seeing the madwoman as a victim. Chesler (1972) argues that the women confined to American madhouses were failed, but heroic, rebels against the constraints of a narrow femininity. Showalter (1985) sees forms of 'insanity' in women as an unconscious form of feminist protest and an attack on patriarchal values.

By the middle of the nineteenth century women predominated among the institutionalized insane. Showalter (1985) described a study by a John Thurnam, medical superintendent of the York Retreat, which indicated that male asylum patients outnumbered females in 1845 by about 30%. However, within a few years and by the time of the 1890 Lunacy Act, the predominance of females had spread to include all classes and types of institutions. The only remaining institutions with a majority of male patients were asylums for the criminally insane, military hospitals, and 'idiot schools'. Outside the asylums, women were also the primary clients at surgical clinics, water-cure-

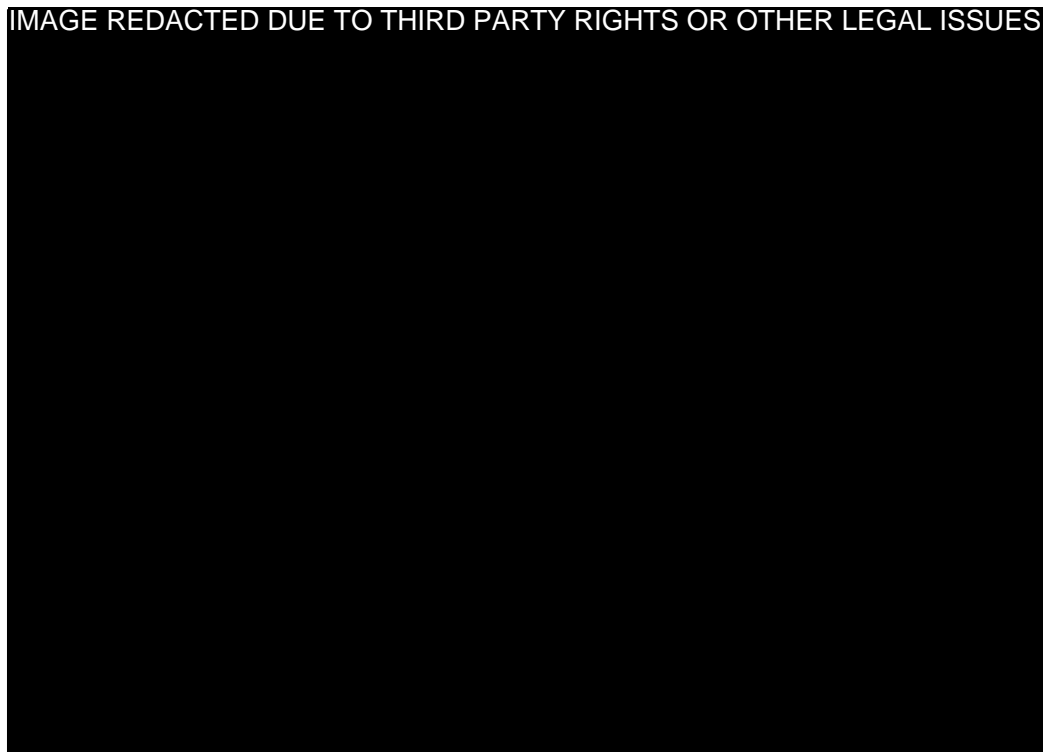
establishments, and rest cure homes. Therefore, by the end of the nineteenth century, women had taken the lead as psychiatric patients, a lead they have retained ever since.

As the number of women increased in the asylums, so the number of women caring for the insane as madhouse proprietors declined. Women as madhouse proprietors had been providing care primarily for female patients in small private madhouses. These services provided by women were in much demand; they were preferred to the services offered in the large asylums. Thus Mary Lamb, who killed her mother, was taken by her brother Charles to a private madhouse run by a woman; and Isabella Thackeray who had developed suicidal tendencies after the birth of her third child was taken by her husband, William Thackeray, to a house run by a woman in Camberwell where she remained until her death. By 1859, however, with the constant protesting of male doctors that they were the only people qualified to treat the insane, women were discouraged from becoming madhouse keepers. At the same time, the madhouses and asylums were increasingly populated by women, but supervised by men.

Treatment of 'mad' women throughout much of the nineteenth century was designed to control the reproductive system. For example, Tilt (1851) argued that menstruation was so disruptive to the female brain it should be retarded for as long as possible. Delayed menstruation, he insisted, gave women a vigorous constitution, and soundness of judgement. Smith (1848), recommended a course of injections of ice water into the rectum, introduction of ice into the vagina and leeching of the labia and the cervix, while Brown (1866) used the surgical practice of clitoridectomy. As a member of the Obstetrical Society he offered the view that insanity was caused by masturbation, so that surgical removal of the clitoris, by helping women to govern themselves, could halt insanity. As Brown became more confident he went beyond clitoridectomy to the removal of the labia.

Some have argued that this approach to treating insanity in women strongly suggests male psychiatrists' fears of female sexuality, because a considerable part of the psychiatrists' defining symptoms of insanity in women had to do with what they saw as uncontrolled sexuality (Showalter 1987). Clitoridectomy has a symbolic meaning; this was the surgical enforcement of an ideology that restricts female sexuality to reproduction, and removes women's sexual pleasure, because it is this autonomous sexual pleasure that was defined as the symptom, perhaps the essence, of female insanity.

Figure 1 **How to get rid of the wife! The introduction to a lunatic asylum.**



Source: Masters, 1977.

Within the asylums, treatment and management was carried out through the control, and moral management, of women's minds, instead of through the surgical knife. This moral management regulated behaviour through the physical design and domestic routines of the asylum. The regime emphasized the ladylike values of silence, decorum, taste, service, piety and gratitude. The sexes were always kept separate and women were more closely and carefully watched than men. This careful watching of females was not only because of their behaviour, but also to protect them from rape and seduction. Hill (1870) argued that there were many reported instances of women being with child by the keepers and by male patients. The work which women were required to do reinforced the conventional sex role behaviours of cleaning, laundry, sewing and cooking. In asylums such as Bethlem, females were involved in every conceivable kind of domestic activity, thus ensuring the maintenance of the discipline of femininity.

The asylum, therefore, subjected women to male authority, and in this respect was not unlike the processes within the family. Rebellion, however, did occur, as many women insisted on self-expression. Granville (1877) regarded female lunatics as always chattering about their grievances, and he recommended that the women be set to work so they would be too busy to talk. These deviations from the ladylike behaviours required were severely punished. At Bethlem, women patients were put in solitary confinement, sedated, given cold baths or secluded in padded cells. Showalter (1987) has pointed out that the excessive confinement of women which replicated the treatment of women outside the asylum, may have contributed to women's excitability and restlessness. Women had few opportunities for physical exercise, because the asylum system provided only genteel, improving and passive activities for them.

In the twentieth century, the oppression which women encounter in their daily lives supports a view of their mental illness as a social product. From this

perspective, it is the sexism within society rather than of psychiatry as such that explains women's mental disturbance. Psychiatry reflects sexism as a part of the broader society.

Psychiatric statistics available on treated mental patients show a predominance of women. The data come from hospital admissions statistics and from General Practices. Women, it appears, are much more likely than men to come under scrutiny of the expert eye of psychiatrists (Russo 1990). Grove (1979) contributes to the debate by observing that women dominate only in particular categories of madness, namely depression, eating disorders, anxiety and phobias. With schizophrenia, it has been claimed that there is no gender difference in psychosis (Rosenthal 1977); but Grove has suggested that women are more likely than men to be diagnosed as schizophrenic, because women's deviant behaviours are more likely to fit within the diagnostic category of schizophrenia.

The figures in Table 1 are taken from Department of Health (1986) Mental Health Statistics, The figures illustrate the dominance of women as patients in the mental health services.

Table 1.**Mental Illness Hospitals and Units - England: All Admissions By Diagnostic Group 1986, 1982-6: Number and Rates per 100,000 population.**

Diagnosed Group	Rates per 100,000 population for 1986.	
	Males	Females
All diagnoses	83,865	113,386
Schizophrenia, paranoia	15,271	14,148
Affective psychoses	8,107	16,526
Senile/presenile dementia	7,624	13,234
Alcoholic psychoses	509	266
Other psychoses (including drug psychoses)	7,445	10,537
Neurotic disorders	4,978	10,291
Alcohol dependence syndrome	8,301	3,508
Non-dependent abuse of alcohol	2,095	1,204
Drug dependency	1,382	806
Non-dependent abuse of drugs	614	278
Personality and behaviour disorders	6,531	7,667
Mental retardation	305	284
Depressive disorders not elsewhere classified	11,740	23,469
Other psychiatric conditions	287	346
Mental illness - diagnosis not stated	65	48
Other conditions and undiagnosed cases	8,601	10,774

From Mental Illness Tables A2.2 and A2.3 (Mental Health Statistics for England, 1986, Booklet 1).

Men are more likely to be diagnosed as suffering from mental illnesses associated with irresponsibility, anti-social conduct or drug or alcohol abuse (Russo and Sobel 1981).

Table 2 gives more recent information for psychiatric hospital admissions in England, and shows that the number of women exceeds the number of men for all durations of stay except for those of 15 years.

Table 2.

All episodes by duration of stay and sex 1991-2, number and rates per 100,000 population, England.

Duration of stay	Males	Females
All durations	110,480	118,350
Under 1 month	68,000	72,000
1 month	21,480	31,540
3 months	8,540	10,430
1 year	1,560	1,860
2 years	1,210	1,610
5 years	200	420
10 years	70	110
15 years	420	380

Source: Department of Health 1995, **Mental Health in England**.

Proponents of the view that women's predominance in mental health statistics follows from aspects of their oppressed social position include Smart (1976), Oakley (1981), and Orbach (1986), and this view is supported by the work of Brown and Harris (1978). Brown and Harris highlight the importance for mental instability of such factors as long-term difficulties in housing, the

impact of unemployment and a lack of confiding relationships. They locate the manifestations of clinical depression in a social, rather than in a purely biological, space, and in so doing they highlight the significance of domestic interrelations in the genesis of mental illness.

An argument put forward by Chesler (1972) is that what is deemed as madness is tied to the performance of sex roles. What is considered madness, whether in men or women, is the acting out of the devalued female role or the partial rejection of one's sex-role stereotype. However, Chesler proposes an asymmetry in the situation of men and women, which arises from the cultural devaluation of the feminine role. Women are liable to be viewed as being mentally ill if they act in feminine or in masculine ways, while men are only likely to be viewed as mentally ill if they act in feminine ways. Consequently, there is a double standard of mental health for men and women; whether women conform to the female standard or depart from it, they tend to be defined as disturbed.

While the arguments of the anti-psychiatrists may be an essential part of the feminist analysis of insanity, care must be taken. As Ussher (1991) observes, the anti-psychiatry dissenters were never deliberately or consciously pro-feminist, and their theories considered women only by default. Ussher cites the example of work done by both Laing (1959) and Cooper (1973), where the issue of gender was not a central part of the analysis. In such works, women's lives are described by, and from, a male perspective, and women and their families are judged within a framework where traditional gender roles are not questioned. In fact, differences from these traditional roles are seen as evidence of pathology.

The dominance of women as psychiatric patients may be due to some conditions, such as eating disorders and depression, being seen as predominantly female problems. Ussher (1991) argues that the women who

are likely to be diagnosed as mentally ill are those who are married, those with children, those who are unemployed, and those who are poor. Definitions of madness are based on value judgements and prescriptions of normality which support existing patriarchal power structures (Daly 1979). Showalter (1987:5) has suggested that women's socialization prepares them for the mask of madness, the 'desperate communication of the powerless'. In this situation, according to Showalter, women who have no legitimate outlet for the feelings of frustration, anger and misery consequent on the experience of living in a patriarchal society, may fall into the psychiatric patient trap. Once labelled as disturbed, women are likely to be given drugs, to be at risk of sexual exploitation by their therapists and to be confined to an institution which denies them many rights (Chesler 1972) (see Figures 2,3,4,5).

Figure 2 **Woman in West Riding Lunatic Asylum manifesting 'Intense Vanity'.**

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Showalter, 1985

Figure 3 A Victorian 'Ophelia' in Surrey Asylum.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Showalter

Figure 4 An alcoholic woman.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Showalter, 1985

Figure 5 **A melancholic asylum patient**

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Showalter, 1985

In looking at the issues and debates around women and madness, the question must be asked - what about men? Men, too, are 'mad', but often men's madness takes a different form in our society. If a comparison is made of the statistics on psychiatric admission and female depression with the statistics on prison populations and male violence and criminality, the scales are more evenly balanced. Men may be 'mad' but they are likely to be positioned as 'bad'. While women are pathologized, men are positioned within the criminal discourse resulting in the sexes being regulated differently.

Ethnicity

The social control functions of psychiatry extend to the differential treatment of black Asian and African people and other ethnic minorities (Littlewood and Cross 1990; Littlewood and Lipsedge 1988; Fernando 1991). Psychiatry has been accused of racism because of its failure to identify the mental health needs of blacks (African Caribbean), and because of its powers of containment and surveillance over the affairs of black families (Fernando 1988; Francis 1988).

As the study of insanity grew in western culture, it carried with it ethnic prejudices present in western societies. In the middle of the eighteenth century, Rousseau's concept of the 'noble savage' offered the view that 'savages' who lacked the civilizing influence of western culture were free of mental disorder. Writers and medical men such as Tuke (1858), Maudsley (1867, 1879) and Pritchard (1835), agreed with Rousseau. Lewis (1965) has pointed to another view in Europe in the nineteenth century, which was that non-Europeans were mentally degenerate because they lacked western culture. In the United States at about this time, psychiatrists were arguing for the retention of slavery (Thomas and Sillen 1972). They used the sixth United States census of 1846 to justify a claim that the black person was relatively free of madness in a state of slavery, but became prone to mental disorder once he/she was set free. The underlying view here was that the inherent

inferiority of the African justified slavery. The history of racism in psychology and psychiatry is as old as the disciplines themselves. Herbert Spencer saw 'primitive races' as having minds like those of the children of 'civilized races'. Francis Galton (1869), the founder of eugenics, considered that a large number of black people were half-witted, while Pearson (1901) saw the extermination of such races as an inevitable part of the evolutionary process.

The application of western psychiatry internationally raises several questions. At one level, there are the issues of employing western ways of thinking about behaviour and illness, irrespective of culture. At another level, there are the biases and perspectives which arise from racism. Such a situation is likely to result in the medicalisation of the effects of stress arising from racial and social problems, a process which obscures inherent racism and the social control function of western psychiatry.

In the UK, it could be argued that psychiatric care is available to all within a National Health Service which is supposed to deliver health care to all residents irrespective of social class or race/ethnicity. Yet there are major discrepancies by class and ethnicity (Townsend and Davidson 1982; Brown 1984). The question of racial bias in psychiatry must be seen in the context of racism as an endemic part of western culture, where psychiatry is but one of the many relevant institutions, using 'institution' in the broadest sociological sense. Within the UK, according to Brown (1984), racist practices are condoned yet seldom acknowledged. Discriminatory practices in British psychiatry are not only maintained by psychiatrists, but also by all other professionals who share in the care of the insane, and particularly by the caretakers, who are the 'eyes' and 'ears' of the other professionals, as they are with the person deemed to be insane throughout the twenty four hour day.

A key process in the diagnosis of mental illness is clinical evaluation. Information about a person's medical history, personality and current mental state is obtained by interviewing him or her. The clinical evaluation is regarded by psychiatrists as composed of objective facts, but according to Fernando (1991), it often constitutes a highly selective account which results in the psychiatrist influencing the content of the information collected. Fernando (1991) cites the example of an Asian patient, who is aware of the negative value attached to Asian marriage customs and is therefore reticent about telling a doctor or social worker about his/her marriage. Such concealment is usually interpreted as secretiveness and deviousness on the part of the 'patient' rather than as following from the social construction of the clinical interview/evaluation process. In the taking of a patient's medical and personal history, there is likely to be an emphasis on particular aspects of the information given which flows from the beliefs and value judgements of the psychiatrist or social worker. A psychiatrist who does not appreciate the context of racial discrimination is likely to be unaware of the pressures impinging on black people, and so may misinterpret their lifestyles and behaviours, relying on racist prejudices. In other words, the psychiatric diagnosis process, with its taken-for-granted notion of objectivity, may result in the practitioners of the discipline being unable to recognize that the evaluations they make are far from objective.

Studies in the United Kingdom show that a disproportionately excessive number of black people are being diagnosed as schizophrenic. Littlewood and Lipsedge (1988) demonstrate that Afro Caribbeans are less likely than white people to seek psychiatric treatment, and when they do they are seldom offered hospital admission, but if they are admitted, they are more likely to be diagnosed as schizophrenic. Psychotherapy is rarely an option; electro-convulsive therapy (ECT) and high doses of medication are more likely. According to McGovern and Cope (1987), there is a high admission rate for African Caribbeans under the Mental Health Act 1983, and an over

representation in secure units and special hospitals. The pressure group MIND (1987) also reports a disproportionate number of African Caribbeans in Britain's mental hospitals.

The diagnosis of schizophrenia is given more frequently to people from immigrant groups when compared to native born people (Bagley 1971), and particularly so for people originating in Africa, Asia and the Caribbean (Dean *et al.* 1976). The incidence of schizophrenia among the African Caribbean population in Nottingham is estimated to be 12 to 13 times higher than that in the general population for the age groups 16-29 and 30-44 (Harrison *et al.* 1988). Littlewood and Lipsedge (1988) found that first admission figures for British born African Caribbean men in London were 7 times the white rate, and for African Caribbean women they were 13 times higher than the white admission rate. They also argue that it is not the original 'immigrant' groups but the British African Caribbean, who have high rates of admission for schizophrenic breakdown.

What then are the reasons for the excessive diagnosis of schizophrenia among black people? Simon *et al.* (1973) in the United States compared the diagnoses given by hospital psychiatrists and research psychiatrists and concluded that the diagnostic differences found between blacks and whites were reflections of hospital psychiatrists' diagnostic habits. In the UK, Littlewood and Lipsedge (1981) suggest that atypical syndromes among black people may be misdiagnosed as schizophrenia. An expression by a black person of anger about, and rejection of, white people and their social structures - usually referred to as 'protest psychosis' - may be a significant element in misdiagnosis (Bromberg and Simon 1968). Work by Loring and Powell (1988) suggests that blacks and whites tend to be seen differentially, even if they exhibit the same behaviour.

There is also evidence of high rates of depression and psychosomatic

illnesses among African Caribbeans compared to whites (Burke 1984). An argument put forward by Knowles (1991) is that the mental health services available to Britain's black population are grossly inadequate, and that this situation may be considered as evidence of racism. All this raises questions about the mental health services available to the African Caribbean population and the manner in which these services are delivered. There are important issues about the admission of African Caribbeans to hospital at a time when mental health care has moved to the community, and questions about the interface between psychiatry and the law. Since most admissions are now voluntary, the use of legal compulsion on African Caribbeans must be examined. Here the evidence suggests that there are higher rates of compulsory admission under the Mental Health Act 1983 for African Caribbean males both as offender and non-offender patients. MIND (1987) suspects that there is a greater use of Section 136 of the Mental Health Act 1983 than shows up in the official figures, because the police have the power of temporary detention over those whom they otherwise have no power to arrest.

The area of treatment provides evidence of the differential treatment regimes offered to black people. For the United States, Rosenthal and Frank (1958) reported that black people showed a high drop out rate from psychotherapy when compared to white Americans. Yomamoto *et al.* (1968) argue that black people are less often taken on for psychotherapy, more often given minimal support and are more likely to end treatment by self-discharge or discharge by the therapist. Further studies by Yomamoto *et al.* (1967) suggested that the differences between black and white people in the use of psychotherapy are due to the ethnocentricity of white therapists. In the UK, Littlewood and Cross (1990) found that stereotyped attitudes led to assumptions that ECT is suitable for non-depressive reactions in black people, and that intramuscular medications are also more useful for black people. Shaikh (1985) observed an excess of ECT among Asians who received the diagnosis of schizophrenia

as compared to the indigenous population. According to Glover and Malcolm (1988), black men born in the West Indies are more likely to be given depot injection of tranquillisers when compared to British born white men.

All these situations which maintain a racist psychiatry may be taken for granted by professionals who offer services to black people deemed to be mentally ill. As already noted, caretakers are the main professionals who manage care over the twenty four hour period. Relevant here (though less often studied) is the organisation of the ward environment, and relationships between the caretakers and black people. Caretakers may contribute to a racist psychiatry by the ways in which they collect and report observations, and the ethos they support in the ward environment and in community mental health facilities. Caretakers are also involved in all aspects of the mental health services, from diagnosis and assessment through to treatment and after care. Although they stand in a less powerful position than psychiatrists, they may share broadly the same theoretical frameworks and may use these to influence and control black people deemed to be insane. Any criticism of psychiatry and psychiatrists may therefore extend to the role of caretakers.

Caretakers are now faced with a multiethnic/multiracial population. This must be addressed if they are to provide effective care. With the employment of black caretakers from Asia, Africa and the West Indies, it is easy to assume that ethnic/racial issues will be addressed. However, black caretakers are not necessarily committed to these issues, and their contribution in making explicit culturally specific needs may be low. It has been argued that black professionals are marginalized in being treated as experts on ethnic issues, rather than as equal professionals (Stubbs 1985). As black caretakers are more likely to be employed as assistants within institutions, they have less professional power, and the few who do have this may find it difficult to voice their critiques.

Psychiatry needs to rethink its conceptualisations and its understandings of ethnic differences in order to avoid collusion with stereotypes about African Caribbeans which are popular in the wider society. In order to deal with this, there may need to be recognition on the part of psychiatry that it is a less precise form of knowledge than it pretends to be, and an openness to the kind of democratic process which is able to take on board the views of mental health service users and their families.

CHAPTER 6

CARETAKERS AND CARETAKING

The focus of the investigation described in this thesis is those who have been involved with the care of the insane over the whole period from 1890 to 1990. The relevant occupational groups range from the caretakers who worked as attendants in the asylums for the insane from the 1850s on, and today's registered mental nurses. This chapter looks in more detail at the nature and history of caretaking. Its central task is to theorize in a historical context about the meaning of the caretaking role for those who work with the insane, and to examine the nature of caring and the principles structuring caretaking work. The chapter argues that, although the men and women who have worked with the insane have been referred to in a variety of ways, essentially their work has been that of caretaking.

The chapter draws on a broad literature relevant to caring and reflects on the historical roles and functions of caretakers since the nineteenth century. Central to the argument developed is the assumption that the concept of 'caretaker' embodies roles, functions and responsibilities which go beyond the medical model of doctor-provided care. Caretaking work involves the provision of twenty four hour surveillance of the insane, which means that caretakers are present throughout the day and night. Caretakers are thus central to social control and other care and treatment processes; their work embraces all the activities involved in providing care in association with the rules and regulations of institutions, medical prescriptions and any ethical issues signified by such activities. Caretaking work also includes all those roles and responsibilities associated with protecting society from the insane, and including some resulting in the incarceration of the insane.

In the twentieth century, the title of workers with the insane changed from 'attendant' to 'mental nurse'. With this change, which followed developments

in science, medicine, the practice of psychiatrists and social perceptions of the insane, came a new emphasis on medical and nursing models in the treatment and care of the insane. Attendants, by becoming mental nurses, derived significant benefits from being a part of the larger profession of nursing, and by taking on the scientific and the medical model in the provision of care. But there were also drawbacks. Many of the previous caretaking roles became redundant, and others were stifled in their development paths. However, it is probably true to say that today the caretakers of the insane are more closely associated with the ideology of pre-twentieth century attendants than with the ideology of nursing. While nursing follows the medical model in seeing the insane as sick and in need of medical treatment, caretakers recognize the insane person's need for guidance and at the same time carry out their social control and their therapeutic functions. Using the title 'nurse' to describe such workers is a way of denying their social control functions. But the occupational and professional dilemmas common to both the work of nurses and of caretakers do also have to be seen in the general context of de-skilling and occupational subordination to medicine (Freidson 1970).

The nature of caring

According to Mayeroff (1971), caring is helping someone grow towards self-actualization, and it is grounded in the worth which the one caring experiences in the other. Gadow (1989) defines caring as supporting an individual's interpretation of his/her own reality; caring means participating with the individual in understanding the particular meaning which his/her experience of health, illness, suffering or dying has for that individual.

Noddings (1984) argues that caring is based in receptivity, with the carer feeling with other who is receiving the care. The caring role of caretakers is a moral ideal, and the starting point for a range of caring actions which include: a positive regard for others; support of others through communication and empowerment; and enhancing individuals by preserving their dignity.

The caring relationship involves power, and such power is expressed in many ways. In Buber's (1970) work, mutuality and reciprocity prevail in caring relationships. For caring to occur, the caretaker and other must be attuned to one another. Caretakers strive for a relationship which decreases vulnerability and reduces the exercise of unilateral power, so that the insane person can decide with the caretaker what the relationship is. There are a number of alternatives. The relationship can be that of child and parent; child and adult; patient, client, counsellor, friend or colleague. This is contrasted with other ways of caring where the caretaker has ultimate authority and exercises definitive power. In such situations, there is no mutuality or reciprocity.

Any of these relationships may be a temporary situation which depends on the needs of the individual and the insight of the caretaker. For example, at times caretakers may be aware of the need to use a social control relationship when the insane person appears to be a danger to himself/herself or the public, but be flexible enough to offer a more equal and therapeutic role when the situation changes. Within the caring relationship, the caretaker needs to be aware of the potential for the exercise of power, which can be expressed in various ways.

Two distinctive approaches to defining the nature of caring are the 'covenant agreement' approach and the 'web of connections' approach. In developing the concept of caretaker, the argument must attend both to the practice of caretaking and the nature of relationships with the insane person. Looking at nurse-patient relationships, Cooper (1989) suggests a covenant relationship where the nurse is in an in-between relationship involving the patient, the doctor and the managers of the institution. This in-between stance is contrasted with Gilligan's (1982) suggestion that the patient-nurse relationship is one of a web of connections - a dialogue, rather than a in-between covenant relationship. Gilligan sees a web of relationship as inclusive rather than exclusive, while a covenant in-between relationship is one which

excludes. A web of connections involves, according to Gilligan, seeing and responding sensitively to needs. This approach to caring draws on the feminist position which sees people and life events as interdependent, with connections sustained by activities of care based on respect, mutuality, reciprocity and attachment rather than on a contract agreement. Gilligan argues that the feminist ethic is inclusive rather than exclusive. The care-receiver knows about his/her needs and is an expert on what he or she does actually experience; the care-giver probably knows what the care-receiver is likely to experience due to the illness and the nature of care available. Dialogue is the key to the giving and receiving of care which fosters the wellbeing of both the giver and the receiver of care.

For the caretaker, the covenant relationship in which there is a contractual agreement to work co-operatively, would in some situations be impossible to achieve. For example in situations where the insane person is unco-operative, the caretaker would continue to give care in the absence of any covenant agreement on the insane's person's side. Even if there is agreement, there could be moral questions. Further, in a situation in which caretakers work with service-users who are illegal drug users, if it is agreed that the service-user would be better off staying in hospital and be supplied with drugs, this covenant agreement would be seen as a moral one from their perspective. Such a covenant agreement would, however, be morally wrong, as it neglects the argument that what the caretaker offers has to be regulated by law, medicine, the institution and professional rules. Caretakers agree to work according to a professional code of practice when they enter the occupation, and this means caring for both service-users who cooperate and those who do not. From this point of view, the nature of caretaker practice suggests that a covenant agreement relationship would encompass all caretaker-service relationships.

That a covenant relationship has limitations does not mean it is analytically useless. In the area of teamwork the covenant agreement asks for full participation between all those workers providing care to the insane. It is in this respect that the covenant agreement is productive for caretakers who can see that their care is most effectively provided when they are a part of the wider caring team. Caretakers are involved in delivering care with both approaches - the covenant and web of connections approaches - at different times, with different insane persons in different situations. The web of connections encompasses the total activities of caretakers with covenant agreements being used as or when required.

Principles governing caretaker practice

In practice the work of caretakers exemplifies certain values. The main ones are the relief of misery and the promotion of wellbeing. Within this value framework, caretakers have historically been concerned with respect for persons, the right to liberty and the right to know the truth.

(a) Respect for persons

The concerns which caretakers have in seeing through their roles and functions while maintaining respect for the insane person are compounded by philosophic and ethical implications of the concepts 'persons' and 'respect'.

'Person' is the status which is granted to human beings. Kant approached the construct 'person' through the concept of reason. He suggested that a person is a rational being who is capable of reasoning from the particular to the general, and possesses the ability to apply these rules consistently to the self and others. This definition creates dilemmas for caretakers working with the insane, as the individuals they care for may not fulfil these conditions consistently. If a person deemed to be insane is thought not capable of rational thought or reasoning, why should he/she be respected? But

caretakers still need to ascribe the status of 'person' to the individual deemed to be insane and irrational because the capacity to communicate and be communicated with remains, although this may be limited or inconsistent.

'Respect' implies a feeling of fellow humanity which is maintained without bias. The question here is whether caretakers can have a disinterested concern for the welfare of others, and to what extent they are able to ensure that free choice is open to the insane. Maintaining 'respect' conflicts with interventions in which the insane person's inability to make choices is assumed. This is most clearly seen in psychiatric certification and protective custody. If caretakers caring for people who are suicidal or self-mutilating leave such people to their own desires, they may blame themselves for failing to limit the person's freedom for his/her own protection. On the other hand, if the person's freedom is restricted, the opposite problem arises, and caretakers face the dilemma associated with exercising control over another person's life. The concept of 'responsibility' is relevant here. Caretakers consider a person responsible for his/her actions and answerable for them. However, in the case of insanity the concept is problematic. For example the McNaughten (1855) ruling exempts a person from the responsibility of murder, if it can be proved that he/she was suffering from a disease of the mind resulting in him/her not knowing the nature and quality of the act or that he/she was doing wrong.

(b) The right to liberty

The classic statement of the principle of liberty is Mill (1962). Mill's view was that the individual's liberty should only be interfered with in self-protection; that to interfere with someone's liberty for his/her own good is not a sufficient reason. Mill's self-protection means a person may be forbidden certain actions only if it can be shown that his/her actions will affect the liberty of others. According to this view, it would be possible, for example, to argue that in certain circumstances people have a right to be unhealthy. However, in

legal terms certain unhealthy situations are condemned, for example infectious diseases, because individuals in this state are likely to harm others. The application of these principles to the work of caretakers is that caretakers need to be mindful that individuals deemed to be insane may defend their liberty by claiming a right to be unhealthy. Since the area of insanity and the criteria for what is or is not insanity are contested, caretakers need to be aware of the danger of labelling as insanity behaviour which is different from that accepted by most people in a given social group. The person asserting his/her right to be mentally unhealthy in such a situation is asserting the right to mind his/her own business. However, if the insane person is a danger to others and himself/herself, he/she can be certified. The restrictions brought on by certification which limit liberty must be proportionate to the limitations in personhood rather than simply on the basis that the caretaker knows better.

(c) The right to know the truth

For caretakers, problems of truthfulness are particularly tested in the area of informed consent, where the person deemed to be insane is expected to consent to treatment without understanding the implications. The issue of informed consent is compounded by those mental states which interfere with comprehension. In such circumstances, the caretaker must determine whether or not the person can process the information given and so appreciate the nature and consequence of what he/she is consenting to. The dilemma for the caretaker is, under what circumstances should the insane person lose the right to give informed consent? Do the non-committed insane ever lose this right? Should the committed insane person have the power to decide his/her treatment? Should caretakers assume that treatment can be given to any insane person who has already lost his/her basic right - the right to liberty - because he/she is regarded as too disordered and is committed?

The early history of caretaking

The main caretaking work germane to the development of the concept of 'caretaker' is that of attendants and psychiatric nurses or mental nurses.

The earliest charitable institutions in England were the houses of hospitality. For example, in about the year 1148, St. Bartholomew's, Smithfield, was the resort of the sick pilgrims suffering from epilepsy, fevers, dropsy, and insanity. The chronicle of St. Bartholomew's shows that in the twelfth century the insane were received along with the deaf, dumb, blind and palsied, and were cared for by the master, usually a priest. He was supposed to be a compassionate priest of good life, and was required to visit the infirm and to console them and to confer upon them the sacraments of the church.

In the leper houses the master himself might be a leper managing the affairs of the institution and supervising workers called 'leper guardians' and 'leper wardens'. In some houses, a monk dependent upon a monastery was the superintendent. These houses or hospitals were heavily staffed by the ecclesiastics who also collected alms to help with their upkeep. Within these institutions were women and men who worked as domestics, laundry workers, cooks and servants, but who also provided care for the inmates. In some houses bedridden inmates were cared for by workers called 'brethren' and 'sisters'. In the almshouse, the master or warden was also known as 'custos', 'keeper' or 'rector'. Usually this was a priest or occasionally a lay person.

When the separation between the insane and those with diseased bodies occurred is unknown, but the first hospital to become a refuge for the insane was the Bethlem Hospital at Bishopsgate in London. The house of Bethlehem was originally founded as a convent by Simon Fitzmary, a citizen of London, who, by deedpoll dated the year 1247, granted unto the church of St. Mary of Bethlehem, all his lands in the parish of St. Botolph without Bishopsgate.

There is no satisfactory information as to the manner or the period of conversion of the convent into a hospital. The earliest record of the reception of lunatics into Bethlem is the record of the visit to the hospital of the Royal Commission in 1403. The earliest Bethlem workers were the brethren and sisters and later the basketmen, gallery maids and beadles. These caretakers were followed by the early equivalent of today's mental nurse, the keeper and the attendant (O'Donoghue 1914).

From the early eighteenth century to the late nineteenth century the most numerous facilities for the insane were the private madhouses. These madhouses were run as businesses, and they were occupied by self-financing and pauper lunatics. Until the building of the county asylums in 1845, pauper lunatics were housed in workhouses, bridewells and institutions such as the Bethlem Hospital (Porter 1987). These institutions had a variety of persons in charge; doctors, clergymen, quack doctors and attendants. A number of proprietors are known to have been attendants. Giving evidence before the 1852 Select Committee, Gillett Wakefield claimed to have been a keeper at Bethlem and Exeter Asylum before he kept his own private madhouse. Isaac Taylor, who in 1839 was taken into partnership by Henry Mannering to run Grove Hall in Yorkshire, was in sole charge of the establishment. It was common for experienced attendants to be resident superintendents of private licensed madhouses. In the metropolitan areas throughout the country, female proprietors were numerous; about one in four houses was licensed to a woman. In many instances these women were the widows or daughters of former proprietors. The transfer of licences to relatives was permitted by law, but it caused concern at the time, because it was clearly the policy of the Commissioners of Lunacy to promote the medical control of facilities for the insane as opposed to control by lay men and women - the attendants (Walk 1961; Hunter and Macalpine and Hunter 1963).

The Medico-Psychological Association was the professional organization of the doctors who worked with the insane. It later became the Royal Medico-Psychological Association and is now the Royal College of Psychiatrists. The Association provided a forum for all professional discussions about how and who should manage, and treat, the insane. It also provided for education, training, examination and the issuing of certificates to doctors and attendants. It enabled doctors to speak with one voice and to make demands on Parliament to ensure that they had the legal right to treat the insane. Sir J.C.Bucknill (1857), a leading doctor and president of the Medico-Psychological Association, argued in **The Journal of Mental Science** that if insanity requires medical treatment, then ladies cannot legally or properly treat such persons, and that laymen and ladies granted licenses to run madhouses were simply being granted permission to speculate and make profits. What was happening at this stage was a fight for the lucrative 'trade in lunacy'. The medical men who owned and ran most of the madhouses wanted to outlaw the lay attendants, both men and women. The doctors stated clearly that the treatment they provided in their madhouses was superior. They characterized the attendants as ignorant, illiterate and of low integrity. In 1829 Burrows argued that in madhouses managed by attendants only custody is offered, while in those madhouses managed by doctors the insane could expect safe custody and cure. These views were given as evidence to the 1928 Select Committee of the House of Lords. There were many examples of lay persons who kept well-conducted houses, and others of mismanagement by doctors (Jones 1955). For example, a Dr James Pownall who became the proprietor of a licensed house, Northfield House in Wiltshire, in 1853, was the following year reported to the Commissioners in Lunacy by one of the visitors as being unfit to be in charge of the establishment after he had struck and shot an inmate.

Questions were raised in Parliament concerning the laws for regulating the granting of licenses for keeping madhouses. The Commissioners of Lunacy

recognized the inadequacy of the prevailing system, and developed procedures for questioning applicants. The questions were designed to explore the applicant's experience, especially his/her medical expertise. By 1860 the official policy as stated by the Commissioners was not to issue new licenses other than to medical men or persons of 'high' character and reputation. This resulted in medical men owning a number of houses, but residing in none of them. Instead they delegated managerial and day-to-day treatments and care to the attendants.

Walk (1961) has drawn attention to the praiseworthy work of attendants such as Sam Roberts, William Couper's attendant at Nathaniel Cotton's house in St. Albans. Walk argues that Sam Roberts, a private madhouse attendant, replaced custodial duties by more psychotherapeutic activities; he later went on to own his own private madhouse. According to Jones (1955), the qualities required of attendants were subject to much debate. Formal instruction was given in 1843 by Sir Alexander Morrison at the Surrey Asylum. The Commissioners of Lunacy attempted to set up a Central Register of Attendants in 1853, which required that the Commissioners had to be notified of all dismissals for misconduct. They stated in 1855 that attendants should combine in their character and disposition firmness and gentleness and that they should be able to direct and promote the employment and recreation of the inmates. There were, however, different attitudes as to what the attendant's role should be in the private madhouses, where most of the inmates were from the upper classes, and in facilities for most pauper lunatics. In the private madhouses the attendant was regarded as a personal servant. It was thought that attendants should not appear other than as respectable domestics, nor should they be allowed to address themselves to the residents other than with respect and consideration. Thus in 1900 the proprietors of Ticehurst Madhouse stated that they selected officers and servants or mess-waiters as attendants, because, in addition to having acquired a sense of discipline and duty, they started with the advantage of

knowing how to speak to gentlemen. In these private madhouses mechanical restraint was replaced by increased personal attendance on the residents. In pauper establishments, however, this was rarely possible; the ratio of inmates to attendants was very high. This situation, combined with the frequent staff changes that took place, and the recruitment of attendants who lacked experience, contributed to defects and abuse within both private madhouses and in facilities for pauper lunatics.

Caretaking activities at the Bethlem

The archives of the Bethlem Royal Hospital provide information which exemplifies the organisation, role and function of caretakers up to and including 1890. The relevant archival sources include: **The Bethlem Hospital Reports (1924)**, and **The Rules relating to the Attendants in the Bethlem Hospital with the Duties of the Several Officers (1954)**.

During this period, the caretakers for the insane were the attendants. In the late nineteenth century there is mention of the attendants as the new category of worker replacing the keeper. Around this time there also seems to have been some improvement in conditions at Bethlem. Inmates who were chained were not chained up in dark cellars, they had no bolts and bars on their doors, their rooms had long airy windows and there were opportunities for exercise. Cleanliness was a priority, with six attendants assisted by inmates doing the cleaning. The care ideology of the attendants was moral treatment and non-restraint. The principle of moral restraint was that put forward by Tuke (1813) in his work at the Retreat in York. Tuke was optimistic about insanity; he argued that the distraction of the inmate's mind was a result of his/her blind surrender to desires and an incapacity to control passions. Therefore insanity could be corrected by a regime to establish self-discipline. Tuke sought to reproduce in the Retreat the intimacy of family relations, with the insane as dependent children and himself as an authoritarian patriarch. Force was to be used only as a last resort. The main aim of moral treatment

was towards assisting the insane to control himself/herself, the theory being that a less coercive form of control would better lead to the internalisation of the principle of self-control.

Conolly (1856) argued that the pursuit of moral principles depended on the qualities of those caring for the inmates to a much greater degree than with bleedings and purges. The principle of non-restraint was to exclude all hurtful excitement from a brain already disposed to excitement; it was said that the physician who understood the non-restraint system knew that the attendants were his most essential instruments. Economy required that responsibility be delegated to attendants under the system of moral treatment and non-restraint; attendants played a dominant role because there were never sufficient doctors to supervise every aspect of treatment. According to Foucault (1961), the asylum was a complicated machine ensuring that the insane were confronted by reason, and that the attendant's actions were closely observed. Thus the asylum became a disciplinary force against staff as well as inmates.

At the Bethlem, as at other asylums, there were very detailed rules and regulations which governed the functions of attendants. An example of such rules was the Duties of Attendants and Servants. These rules were recorded in rule books which were given to attendants on being employed (see appendix 1). The rules clearly show how the attendants' life throughout the working week was regulated. The emphasis of their work was on cleanliness, the occupation of the inmates and the locking and unlocking of various rooms and buildings. Their work activities included the washing, shaving and dressing of the inmates, the examination of inmates for bruises, soreness or any skin discolouration, and the reporting to the medical officer any inmate who became sick. For each day of the week there were particular activities; for example, chapel on Sundays, laundry on Mondays and baths on Saturdays. If an attendant went out for an evening he/she would have to be

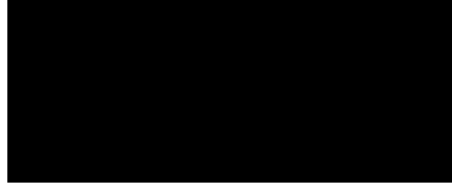
back no later than 10 pm.

It is clear that in the rules and regulations of the Bethlem Hospital, discipline is the first and most important duty of the attendants. This discipline, which was closely associated with surveillance, was highlighted in two aspects of the attendants' work. Firstly, discipline and surveillance were imposed on the attendant, who in turn imposed similar discipline and surveillance on the inmates (see Figure 6). Control, restraint and surveillance were evident in the physical construction of the institutions. This type of architecture was advocated by Jeremy Bentham, who referred to it as the 'Panopticon' or the 'inspection house'. A design such as this facilitated constant surveillance and inspection by permitting an overview of corridors, workrooms and cells by a single person or by three persons at most. This provided for effective surveillance at a minimum cost. Bentham saw his plan as a gesture of liberalization for the insane, as chains and other physical restraints were supplanted by a more efficient restraint through architecture (Doerner 1981).

Secondly, the attendants were expected to set an example through their behaviour by demonstrating industry, order, cleanliness and obedience. Much of the disciplining of the inmates was carried out by utilizing the inmates' labour. While some attendants cared for debilitating inmates or surveyed inmates taking exercises, others spent much of their time supervising inmates' work. From the rules and regulations, it can be seen that order and security were the major concerns of the managers of Bethlem (see Figure 7). The attendant's role and function revolved around cleanliness, dress, distribution of food, exercise in the open air, occupation, general quietness, good conduct and amusement. Little is mentioned about moral treatment, and security occupied most of the rules and regulations, particularly with regard to the care of keys, tools and cutlery.

Figure 6 Plan of an intended **London Asylum for the care and cure of the insane.**

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Donnelly, 1983

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES

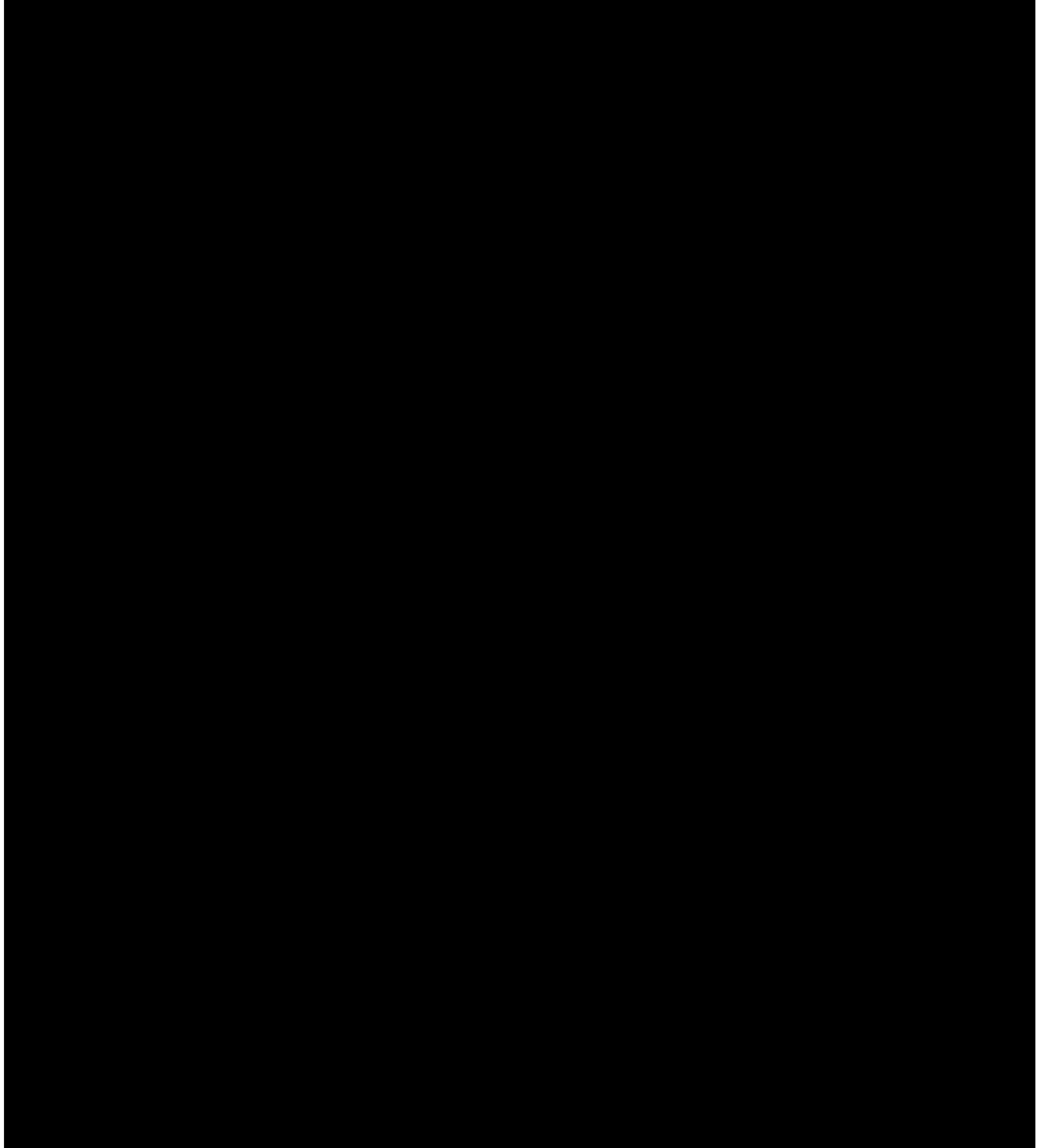


Figure 7 The men's ward in Bethlem in 1860.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Masters, 1977

The training and practice of attendants

In 1891 Burdette noted that attempts should not be made to get ladies and gentlemen, that is, people with a 'gentle' upbringing to work as attendants, because they would be unable to perform the duties required of an attendant as they would be out of sympathy with the tastes of the inmates. For Conolly (1847) the ideal recruit was a member of the 'respectable', rather than the 'rough', section of the working class. However, he argued that because pay and prospects were not sufficiently attractive and in practice strength was often prized above benevolence, there was a tendency for attendants to be recruited from the 'rough' classes of society.

W.A.F. Browne (1837) at the Chirchton Royal Hospital in his book **What Asylums Were, Are and Ought to be** had called for some system of instruction for attendants. However, it was not until between 1842 and 1844 that Sir Alexander Morrison developed and gave the first known set of lectures to attendants at the Surrey asylum. This was followed in 1854 by a course of 30 lectures developed and given to attendants and doctors by Browne at the Chirchton Royal Hospital. In 1871, Henry Maudsley proposed that the Medico-Psychological Association should set up a registry of good attendants, but he did not attempt to link this with any form of training. It is remarkable that Florence Nightingale took no interest in the training of attendants. It was not until 1899 that the Medico-Psychological Association started to manage the contents of the training curriculum and to grant certificates. The development of training enabled attendants to establish themselves as carers of the insane. This gave them mobility and enhanced their promotion prospects.

Throughout this period training was managed mainly by doctors. The Bethlem Minutes of 1892 make reference to lectures to attendants, and a male charge attendant is commended for making a series of large diagrams of the human body. This was the first recorded instance in the Bethlem of

attendants taking part into their own training. Courses at this time extended over two years, and included exercises under the head and charge attendants, with clinical instruction by the medical staff and lectures taking place on the wards. Examination papers were set centrally by the Medico-Psychological Association, with the conduct of the examination and the marking of papers left to the institution's medical superintendent and an external assessor. The Medico-Psychological Association published a training handbook in 1885. This handbook detailed what was required in the training of attendants. It is clear from the content of the handbook that the approaches to non-restraint and moral treatment were less emphasized, and instead the development of a scientific understanding and treatment of the insane was given priority. This situation was further consolidated with the sovereignty of the doctor in institutions for the insane, and the emergence of the caretaker as the doctor's assistant.

It was at this time that attendants started to be called mental nurses. The actual title of the training handbook was **Handbook For Mental Nurses: Handbook For Attendants on the Insane**. The members of the Medico-Psychological Association who contributed substantially to the publication of the handbook were all doctors working in asylums: A. Campbell-Clark, C. McIvor-Campbell, A.R Turnbull and A.F. Urquart. The preface of the handbook goes as follows:

'This handbook has been prepared in the hope of helping attendants on the insane to a due understanding of the work in which they are engaged. It is sought to give them such simple notions of body and mind in health and disease, such instructions for the management of those maladies with which they are usually brought in contact, and such rules for their guidance in matters of every day experience as will enable them to do their work with greater intelligence and watchfulness. It is

designed that these instructions should aid attendants to carry out the orders of the physicians; but it is to be distinctly understood that in no case is anything contained in this book to over-ride the special rules of an institution, or special orders in regard to any individual case.'

The handbook contained five chapters; CHAPTER I, The Body - its General Functions and Disorders; CHAPTER II, The Nursing of the Sick; CHAPTER III, The Mind and its Disorders; CHAPTER IV, The Care of the Insane; and CHAPTER V, The General Duties of Attendants. Chapter IV contains the following care guideline: 'It is important to attend carefully to the bodily health of patients. All the insane must be regarded as patients requiring special care and management. In managing the mental condition, the arrangement of an asylum, its discipline and daily routine are intended to: promote recovery, and to secure that the patients shall be kept under observation. Patients must never be thoughtlessly ridiculed. The attendant must correct insane habits, promote good habits, maintain regular occupation and amusement. Attendants must carry out their duties with firmness, kindness, tact, persuasion and self control.'

Along with the certification from the Medico-Psychological Association, successful candidates also received certificates in first aid and massage from the St. John's Ambulance Association. Caretakers were now seen as doctors' assistants, and most of the practical autonomy they had had in providing care for the insane had disappeared (Hunter 1956; Walk 1961).

By 1891, the Medico-Psychological Association had acquired the prefix 'Royal'. It extended the training of attendants to three years. At this time, there were many mental nurses involved in training, but control over the content of the training remained with the doctors. The syllabus was dominated by the basic sciences - anatomy, physiology and neurology - and only reached any

consideration of the care of the mentally ill after almost every other subject had been exhausted. This tendency grew, despite criticism from some members of the Royal Medical-Psychological Association and some mental nurses. At this time the attendants, supported by some of the members of the Royal Medico-Psychological Association, started the Asylum Workers' Association with the aim of promoting the interests and status of attendants and others engaged in mental nursing. This Association provided a forum for attendants to air their views and to work together. It was from this beginning that the national Asylum Workers' Union developed. The mental nurses expressed their opposition through their union to the training being controlled by doctors, incurring the displeasure of the members of the Royal Medico-Psychological Association. The main point of contention was the attendants' move towards self-determination. These developments coincided with the development of the General Nursing Council examinations for general nurses, with state registration becoming law in 1919. Despite the leadership given by mental nurses in developing training, examination, certification and registration before general nursing, the various Bills for state registration ignored the claims of the mental nurse for registration. When in 1919 the state registration act was passed, provision was made for mental nurses in the supplementary part of the register, and in 1920 the General Nurses Council resolved to accept the Royal Medico-Psychological Association certificate as evidence of training.

Hunter (1956) argued that the training of the mental nurse was parallel to the training of mental hospital doctors, but with the transition from asylum to mental hospital there was increased pressure for these institutions to be more like general hospitals. Throughout these changes the training of the mental nurse was adjusted to follow closely the training of general nurses, and by 1923 the General Nursing Council and not the Royal Medico-Psychological Association was responsible for the training of the mental nurse.

The work and function of caretakers changed when they became mental nurses and were no longer called attendants. At the same time, psychiatry, perhaps jealous of the therapeutic and treatment advances of general medicine, became more interested in physical treatments. The role of caretakers and their function as attendants emphasized non-restraint and moral treatment; as nurses the emphasis was placed on physical treatments and chemical restraint. What took place was a fundamental change in the nature of caretakers' work due to the rise of physical methods of treatment.

The caretakers of the twentieth century started out as mental nurses; they then became psychiatric nurses, and now they are referred to as mental health nurses or mental health workers. Their training remained completely within the medical model until the 1982 syllabus, which re-emphasized the interpersonal aspects lost when the occupational title of caretakers changed from 'attendant' to 'mental nurse'. With the current Project 2000 training initiatives, training for all branches of nursing shares a common foundation, and a specialist pathway leads to mental health qualification. The modern role and function of caretakers now embraces both institutional and community care. They have regained some of the professional autonomy which was lost when doctors became dominant in the affairs of the mentally ill, and some of them are now questioning the chemical and institutional constraints placed on their role and function. They are trying to recapture through the disciplines of psychiatry, sociology, psychology, philosophy and counselling some of the humane approaches to care which were started by the attendants.

Before 1854, caretakers could and did effectively run madhouses in a way which emphasized care. The care offered omitted mechanical and chemical restraints, and emphasized respect for the individual. By 1857 the medical establishment was making a bid for the right to control and medicalize the insane. Caretakers found themselves working as assistants to doctors and having to pursue roles which fitted asylums and madhouses organized along

the same lines as general hospitals. Their work now consisted of following and maintaining rules and regulations which stipulated the need for surveillance, discipline and cleanliness.

CHAPTER 7

MENTAL HEALTH LEGISLATION

Mental health legislation in England and Wales is concerned with two basic questions: how should patients and staff be regulated, and how should staff be regulated in the provision of treatment and care? This chapter addresses the changes which took place between 1890 and 1983 in mental health legislation. It examines the social context of mental health law and the details of the 1890, 1930, 1959 and the 1983 legislation; and how these acts provided for the administration of the mental health services, admissions systems, the treatment and care offered, and discharge processes.

In order to understand how mental health law works, it is necessary to analyse it in its social context. The mental health legislation which deals with compulsory admission and treatment is a means of overt social control. It strengthens the social control function of the psychiatrist by ensuring that psychiatry can successfully accomplish its social control role and function. On the other hand, mental health law may also encourage non-compulsory care. The law can also provide for safeguards against the abuse of compulsory powers and other infringements of rights and liberties. Thus, mental health legislation can in practice be a means of defending the rights of the oppressed as well as being an instrument of injustice (Cavadino 1987).

Early lunacy reform

In the eighteenth century the insane were locked up in madhouses, in the nineteenth century, lunatics were consigned to asylums, and in the twentieth, the mentally ill are cared for in hospitals and in the community (Jones 1955).

The insane first received mention as a separate group in the community in 1744. Lunacy reform was not an isolated event; it was associated with penal law and reform, factory law and reform in education and public health. It

sprang from a new and growing conception of the community's responsibility for the wellbeing of its members. The patterns of reform followed more or less a familiar pattern. First came a sense of public unease with existing conditions. Changes were then instituted by influential local individuals and by philanthropists. These situations attracted the attention of members of Parliament, who pressed for the establishment of select committees. The reports of such select committees then usually resulted in a new law being put to Parliament.

The Vagrancy Acts of 1713 and 1744 provided for the detention of those who might be dangerous, and the Madhouse Act of 1774 ensured minimum standards of care in private madhouses. Attempts to improve the conditions in which the insane were kept resulted in the County Asylum Act of 1808. From 1808 to 1890 more than twenty Acts of Parliament dealing with the care of the insane were passed.

The insane who were involved in minor crimes up to the early nineteenth century were housed in the county goal or bridewell. Criminal insanity as such was not recognized before 1800 and insane persons who committed crimes were held responsible for their actions and sent to prison. The Criminal Lunatics Act of 1800 introduced for the first time the conditions under which a person might be detained as a criminal lunatic. The Act was hastily passed within a few weeks of the trial of James Hadfield, who made an attempt on the life of King George the 111, and followed another similar case, that of Margaret Nicholson who also threatened the King's life.

With the category of criminally insane established, the problem of where to accommodate such persons was recognized. Most found themselves either in a Bridewell, a gaol, a house of correction or Bethlem. After the introduction of the county asylums, some criminal lunatics were sent there, although most remained in a penal institution. Between 1800 and 1840, there were many

celebrated cases: for example, Bellingham who shot Spencer Perceval in the lobby of the House of Commons; Edward Oxford who shot Queen Victoria on Constitution Hill; and Daniel McNaughton who shot Edward Drummond, Sir Robert Peel the then Prime Minister's secretary (Jones 1955). These cases resulted in the Criminal Lunatics Act of 1838 which amended the 1800 Act by drawing a distinction between lunatics who actually committed a crime and those who were thought to be about to commit a crime because of a deranged mind. The case of Daniel McNaughton resulted in the McNaughton Rules of 1843 which are still in force today. The McNaughton Rules outline the four principles that:

'A criminal is punishable if he knows that what he did was contrary to the law, notwithstanding the insane delusion'; 'If the accused person is deluded, his culpability must be judged as if the delusion was in fact true, if he supposes that a man intends to kill him, and kills that man, believing his actions to be one of self-defence, he is exempt from punishment: but if he believes only that the man has damaged his reputation, and kills him, the accused is punishable by law as if he were sane'; 'The decision as to the prisoner's sanity or otherwise must be made by the jury, since it involves the determination of the truth of the facts disposed to, which it is for the jury to decide: and the questions are not mere questions upon a matter of science, in which case such evidence is admissible'; 'The onus of proving insanity rests with the defence - that is to say, the accused person is presumed sane until it is proved that he is not'; and 'The prisoner must be proved to have been insane at the time when the crime was committed. It is at least theoretically possible for a person perviously certified insane to bear full responsibility for a crime committed in a lucid interval' (Jones 1955:212).

All these Acts which addressed the care of the criminally disordered person were drawn up and executed in the context of a profoundly class-based understanding of society. The category of insane persons who possessed

estates and wealth came within the ordinary Lunacy Acts, but, as noted above, they occupied the special category of Chancery Lunatics. The provisions for Chancery Lunatics had their origins in the *Praerogativa Regis* of Edward 11 which stated that: 'The king shall provide, when any happen to fail of his wit, as there are many having lucid intervals. that their lands and tenements shall be safely kept without waste or destruction, and that they and their households shall live and be maintained completely from the issues of the same; and the residue beyond their reasonable sustenance shall be kept to their use to be delivered unto them when they recover their right mind; so that such lands and tenements shall in no wise within the time aforesaid be aliened...' (Jones 1955:221).

Tuke argued in 1882 that the procedures and provisions for Chancery Lunatics provided protection for the property but not for the person, and that by the eighteenth century relatives would petition the Lord Chancellor to enquire into the condition of an alleged lunatic in order to prevent him/her from wasting a fortune (see Figure 8). If the Lord Chancellor found that the suspicions were true then the property was passed into the protection of the crown. The majority of Chancery Lunatics were housed in private madhouses where they lived under better conditions than the criminal lunatics consigned to houses of correction, Bridewells or gaols. Some categories of both Chancery Lunatics and Criminal Lunatics were sent to Bethlem. These arrangements continued until plans were drawn up for the building of Broadmoor which would serve as a specialist establishment combining the medical facilities of an asylum with the precautions against escape or violence to be found in a prison.

Figure 8 **Relatives visiting an uncle in an asylum in 1851.**

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



'How about altering your will now, Uncle?'

Source: Masters, 1977

The 1890 Lunacy Act

1890 saw the Lunacy Act on the statutes. The Act was considerably longer and more detailed than previous attempts at lunacy legislation. According to Jones (1955), the Act bears the heavy impress of the legal mind. Its primary object was the prevention of wrongful detention by the imposition of legal controls. This philosophy of legalism in the treatment of the insane can be understood by looking at the general political context and the state of psychiatry at the time. The dominant political ethic supported individualism and liberty, and saw adult citizens as rational individuals with free will who were entitled to the legal protection of their civil freedoms (Unsworth 1987). At the same time, the asylum system had increased in size and numbers, but was failing to deliver its curative promise and was developing more as a custodial institution requiring legal regulation. Within such a setting, the caretakers who looked after the insane were seen as maintaining harsh regimes which included mechanical, chemical and dietary restraints.

The development of this piece of legislation for the control of the insane occurred in a climate which had become increasingly critical of the services available for the insane. In 1877 **The Lancet** sponsored a fact-finding commission on 'The Care and Cure of the Insane', under the direction of Dr. Mortimer Grenville. Dr Grenville visited a number of public and private asylums in London and the home counties. His report stressed that asylums and madhouses were regressing from the standards set in 1845. The standards of relevance here related to the suggestions for the improved care of the insane for which the parliamentary reformers in 1827 were arguing, along with the humanitarian changes of the 1845 Lunatics Act. The parliamentary reformers wanted the sexes to be separated, dormitories to be properly ventilated, courtyards to be airy and dry and baths with hot and cold water to be provided. On the physical care of the patients, they wanted to know what steps were taken to ensure personal cleanliness, how often the patients had baths and the amount of exercise they got. On occupation, they

wanted to know how much manual work was done by the patients, and how this was balanced against occupation in the arts, the sciences and literature. On the moral treatment of patients, they wanted to know that patients were being encouraged to demonstrate self-restraint and self-respect. Staff were at all times expected to be kind and supportive to the patients (Jones 1972:106-7).

The main changes required by the 1845 Lunatics Act were social and humanitarian. The Act asked for the blurring of the distinction between mental and physical disorders; the protection of the insane against illegal detention, and the involvement of social work and social care workers. One of the main achievements was in the area of illegal detention. The Lunatics' Friend Society was founded in 1845 by Luke James Hansard, the son of the original printer to the House of Commons. Along with Lord Ashley and his group of parliamentary reformers, they petitioned parliament and achieved the protection of the British subject from unjust confinement on grounds of mental derangement (Jones 1972).

Dr Grenville's fact-finding commission mentioned examples of good practice, such as medical officers visiting wards unexpectedly by day and night, but added that everywhere there was evidence of attendants maltreating and abusing patients when the medical officers' backs were turned. He further commented that lack of a personal touch and of money were the real evils of the system. He recommended a radical change of attitude to the insane.

Despite the various commissions and reports of the period, there was little support for humane treatment (**The Times** Law Reports 1884). In a leading article **The Times** commended in 1877 that, 'If lunacy increased as at present, the insane will be in the majority, and freeing themselves will put the sane in asylums' (**The Times** 5.4.1877). In 1883 a Lunacy Bill was introduced to Parliament by the Earl of Silborne. This did not go far because of the lack of

support at the time. In 1884, Lord Milton argued in Parliament that the state of the lunacy law was unsatisfactory and constituted a serious danger to the liberty of subjects. He emphasized that a person could be confined in an asylum by anybody, on the statement of anybody, and that it was shocking that such a state of affairs should exist. Members of Parliament were at this time seeking more legal control over the insane. Lord Shaftesbury, the chairman of the Lunacy Commission, argued that some revision was required, but that there should be no increase in legal formalities. When Shaftesbury died in 1885, the way was open for the introduction of the measures he had so long opposed. On January 31 1887 two Bills were introduced, but it was not until March 1890 that the Bill was passed and placed on the Statute Books (**Hansard** 1888, 1889, 1890).

The 1890 Lunacy Act is divided into five sections: Administration, Admissions, Care and Treatment, Discharge and Miscellaneous Provisions.

(a) Administration

The Lord Chancellor was to be the ultimate authority. He was responsible for the appointment of the Lunacy Commissioners who sent their reports to him. He appointed the Chancery visitors and could intervene directly in the affairs of any single patient. The local authority, through the county borough council, was responsible for the public asylums and the private madhouses. These authorities were responsible for building and maintaining the asylums and appointing visiting committees.

(b) Admissions

The Act provided for four methods of admission to either an asylum or a licensed madhouse. *Admission by a reception order* or petition could be obtained in private cases but not for pauper lunatics, where a relative or other person had to petition a Justice of the Peace with two medical certificates. The petitioner had to be over twenty-one years of age, have seen the person

during the past fourteen days and had to undertake to visit the person, either personally or by proxy, in the receiving facility every six months. *Admission by an urgent order* was for those private cases where there was no time for a lengthy procedure of certification. This procedure involved a relative's petition and one medical certificate; a magistrate's order was not necessary. Reception into a facility had to take place within seven days or the person had to be discharged. *Admission by summary reception order* was the method of admission for pauper lunatics. Petitions were made by the Poor Law Relieving Officer or the police. These people were responsible for notifying the Justice of the Peace who had to issue a justice's order. Two medical certificates were also required. *Admission by inquisition* was applied only to Chancery Lunatics, the category of insane people who were wealthy and possessed estates which were placed under statutory supervision. Here the Judge in lunacy could direct the Master in lunacy to examine an alleged lunatic and if he considered him/her to be of unsound mind a certificate to this effect was issued. A person would then be appointed to administer the estate, and the lunatic would be admitted into an asylum or confined singly. If the alleged lunatic wished he/she could contest the issue of his/her sanity by requesting a trial by jury.

There were detailed regulations to prevent collusion between the parties responsible for the processes of certification, including between petitioner and doctor, doctor and doctor, and doctor and the manager of the facility to which the person was sent. The duration of an order was one year. It was then renewable after periods of two years, three years and five years and successive periods of five years on the report of the medical officers of the facility to the Lunacy Commissioner.

(c) Care and treatment

This section of the 1890 Lunacy Act had three parts: Reports and Visitation; Mechanical Restraint; and Correspondence.

The Reports and Visitation section ensured that all public and private madhouses were visited at least once each year, and that reports were sent to the Lord Chancellor to be laid before Parliament. Mechanical restraint by the use of instruments and appliances was only to be used for the purposes of surgical or medical treatment, or to prevent the patient injuring himself/herself or his/her fellow patients. A medical certificate was necessary for each instance of restraint and a report book had to be kept; all such records were sent to the Commissioners in Lunacy once every quarter. The use of mechanical restraint and instruments made the asylum keeper's job much easier. Restraints were applied to the melancholic, the maniac or the violent patient. Suicidal patients did not have to be watched, and night attendance was avoided by strapping patients in their beds. Alongside these mechanical restraints was the use of water, air and electricity as cures for insanity (See Figures 9,10,11,12,13,14,15,16). All letters written by all patients, whether private or pauper, to the Lord Chancellor, a Judge in Lunacy, a Secretary of State, a Lunacy Commissioner or a Chancey Visitor, were to be forwarded unopened.

Figure 9 **Mechanical restraints used at the Hanwell Asylum.**

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Showalter, 1984.

Figure 10 Manacles and gloves for the more violent.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



For the more violent: gloves . . .

and manacles.
(Royal Bethlem Archives)

Source: Masters, 1977

Figure 11 A sketch of Norris in his iron cage in the Bethlem. This picture was mass-produced in the form of cheap engravings and used to great effect by the reformers.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Scull, 1981.

Figure 12 The Rush tranquilliser chair. Contrived by Rush in Pennsylvania Hospital to cure madness. It binds and confined all the parts of the body and keeps the trunk erect, thus lessening the flow of blood to the brain. Was seen as a sedative to the tongue and temper as well as the blood vessels. Used for durations of up to four hours.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Scull, 1981

Figure 13 Gyrating chair similar to the one used by Benjamin Rush to increase the blood supply to the head.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Alexander and Selesnick, 1967.

Figure 14 Rotary motion machine for treatment of the insane.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Skultans, 1979.

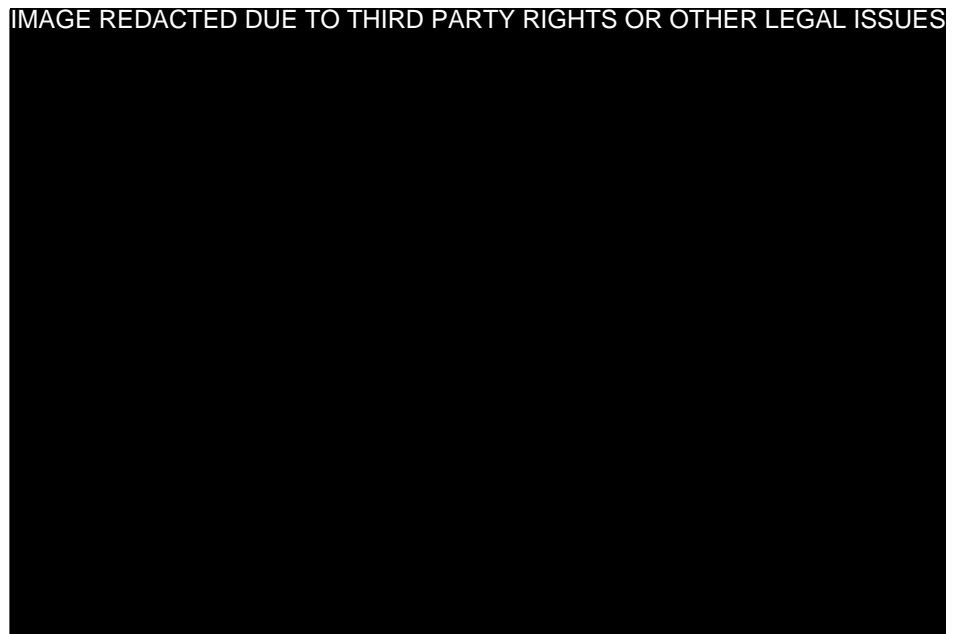
Figure 15 The douche: a method for calming violent lunatics, nineteenth century.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Skultans, 1979.

Figure 16 Electro convulsive therapy treatment.



Source: Showalter, 1985.

(d) Discharge

A patient might be granted absence on trial or full discharge. Any patient escaping from an institution might be recaptured within fourteen days, but after the expiry of that period, he or she could not be returned to the asylum unless fresh proceedings for certification were completed.

(e) Miscellaneous provisions

This section of the 1890 Act covered two areas: single lunatics and penalties for obstructing a Commissioner. The Act provided for the inspection of the accommodation and care of single patients confined in their own homes. It made it possible for Commissioners to visit and to receive medical reports on the patient's mental and physical condition. Should the Commissioner feel that the patient was not being cared for adequately, this information was to be passed on to the Lord Chancellor who had the powers to secure the patient's transfer to an asylum. Penalties for obstructing a Commissioner in the course of his duties or helping a patient escape ranged from fines to imprisonment.

The 1930 Mental Treatment Bill

While the Lunacy Act of 1890 represented the legal view of mental illness, the Mental Treatment Act 1930 proposed that there should be a reduction in the emphasis on civil legislation for the mentally ill. Instead, the emphasis was on the reduction of legal formalities in the interest of early and successful treatment of psychiatric disorders. This Act provided for voluntary treatment, the establishment of psychiatric out-patient clinics and observation wards, and the abolition of out-dated terminology such as 'pauper' and 'Poor Law'. The concept of 'asylum' was replaced by that of 'mental hospital' and 'insane' and 'lunatic' were replaced by the alternatives of 'patient' and 'persons of unsound mind'.

Authority for administering the Act was vested in the Minister of Health, who appointed commissioners to the Board of Control. The Board of Control's

task was to supervise the visitation of asylums and private madhouses, and report to the Ministry of Health. The Act established three categories of patients; voluntary, temporary and certified. *Voluntary patients* were any individuals who wished of their own free will to undergo mental treatment. They could make a written application to the person in charge of any establishment approved by the Board of Control, and could be received as a patient without the need for a reception order. For persons under sixteen, the parent or guardian could make such an application. The application would have to be supported by a recommendation from a practitioner approved by the Ministry of Health or the local authority. A voluntary patient could discharge himself/herself by giving seventy-two hours notice. Such voluntary patients could lose their voluntary status if it was deemed that they had become incapable of making decisions about his/her treatment. Then it would be necessary to discharge them and institute a certification process.

Temporary patients were defined as people suffering from mental illness who could benefit from treatment, but were unable to express their willingness or unwillingness to receive such treatment. The intention here was to keep the patients in hospital when it was thought that a short period of time would be enough to produce an improvement in their mental condition. Temporary patients could only be admitted with petitions from a near relative and two medical certificates. If a patient regained his/her volition, he/she could become a voluntary patient or be discharged within twenty-eight days. The initial duration for a temporary order was six months, and this could be extended to two further periods of three months with the permission of the Board of Control. The procedure for certified patients was established under the 1890 Lunacy Act and the Mental Treatment Act did not change this.

The 1930 Act was seen as contributing to public health, mental hygiene, national efficiency and social reconstruction, and at the same time to reduce legalism and follow the principles of informalization and voluntarism in the

care of the mentally ill (Unsworth 1987). The move towards voluntarism, and a therapeutic hospital community, saw caretakers involved in such activities as welcoming into the ward environment the Red Cross and county libraries. Women patients were allowed to use hospital facilities to cut their hair and improve their dress. The therapeutic value of such activities started to be widely recognized. Caretakers were also involved in making meals and mealtimes a social activity aimed at re-socializing the patient. In almost all hospitals, caretakers provided programmes of entertainment activities covering the whole year. There were cinema shows, and sports such as cricket, football and hockey. Most hospitals had regular dance classes and held dances for both male and female patients. These dances significantly marked another change in the twentieth century care of the mentally ill: the beginning of a breakdown in the old rigid system of segregating the sexes. In a typical nineteenth century mental hospital, the male side was headed by a male caretaker, an attendant, or a nurse, and the female side by a female caretaker, a matron. Each side was staffed by staff of the same sex. The segregation of the sexes could be considered as placing limitations on the therapeutic environment caretakers were trying to foster, as male and female patients were prevented from learning how to live together. On the other hand, without adequate supervision, with sex desegregation, there was a danger that women patients might be exploited by other patients or by caretakers, and there were also problems around issues of confidentiality and privacy.

The 1930 Act also marked a change in the ward system, from closed to open wards. The ideology of voluntarism indicated that more doors should be open with some patients free to come and go independently. The introduction of the open door policy aroused tensions in some older caretakers who felt they were losing their control over patients. As the open door policy became more acceptable to the caretakers, they found their roles extending away from the hospital to the supervision of patients in the grounds of the hospital and with

patients out for short breaks, and weekends. The system of locked wards continued alongside these changes, and the image of caretakers with their keys jangling remains a feature of mental health facilities today.

Training courses were by now well-organized. Doctors were required to gain a diploma in psychological medicine, and this qualification is still required today. For the caretakers, social work and occupational therapy courses were developed.

The 1959 Mental Health Act

On October 22, 1953, the appointment was announced of a Royal Commission 'On The Laws Relating to Mental Illness and Mental Deficiency'. From this time on there was a tremendous increase in the public's interest in mental illness problems. This coincided with clinical and social progress in the care and treatment of the mentally ill.

The terms of reference of the Royal Commission on Mental Illness and Mental Deficiency were: 'To enquire into the existing law and administrative machinery governing the certification, detention, care, discharge and supervision of persons who are alleged to be suffering from mental illness or mental defect, other than the criminally insane, and the extent to which voluntary care and treatment should be extended' (Royal Commission on Mental Illness and Mental Deficiency 1957).

When the Royal Commission presented its report to Parliament, its recommendations led to the 1959 Mental Health Act. Arguments about the need for new legislation was part of a general movement towards a more interventionist state. The 1947-51 labour government passed a series of measures, including abolishing the Poor Law and replacing piecemeal welfare structures with the more comprehensive, rationally organized and freely available services of the welfare state. A new Mental Health Act was

needed to develop state psychiatry as the mental health counterpart of the National Health Service Act of 1946, the National Insurance Act of 1946 and the National Assistance Act of 1948. Taken together, this legislation was designed to provide for a national minimum of social, physical and economic wellbeing. The 1959 Mental Health Act was therefore an integral part of the architecture of the welfare state.

The Act repealed all previous lunacy, mental treatment and mental deficiency legislation, and provided a single code for all types of mental disorder. The sections of the Act which introduced new thinking into mental health legislation were: Definitions, Administration, Mental Health Review Tribunals, Admission to Hospital, Guardianship, Criminal Patients and the Management of Property.

(a) Definitions

Mental disorder was defined as mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.

(b) Administration

Administration was vested in the Ministry of Health by the terms of the National Health Service Act of 1946. The Act dissolved the Board of Control and established the Mental Health Review Tribunal. Local administration was assigned to local authorities, which were responsible for the provision of facilities for the mentally ill; all residential accommodation; centres of training and occupation; the appointment of mental health welfare officers; and ensuring the guardianship rules of the Act. The local authorities were the registration and regulation bodies for mental nursing homes. Mental welfare officers employed by the local authority were given powers of entry and inspection. They could apply to a magistrate for a warrant to search for and remove a person believed to be suffering from mental disorder. They could

make application for a person to be admitted to hospital or to guardianship.

(c) Mental Health Review Tribunals

Mental Health Review Tribunals replaced the Board of Control. One tribunal was established for each Regional Hospital Board Area. These reviewed individual cases of compulsory detention at the request of patients, their relatives or the Ministry of Health. Each Tribunal consisted of legal members, medical members and members who had knowledge of administration and the social services. Legal members had to chair all Tribunal sittings.

(d) Admissions

Under the Act, patients could be admitted to any hospital or mental nursing home without formalities of any kind and without liability to detention. Children over sixteen could be admitted for treatment without the consent of their parents or guardians.

Three kinds of compulsory admission were established: admission for observation, admission for treatment and emergency admissions. *An observation order* was of twenty-eight days' duration. It had to be made on the written recommendation of two medical practitioners, who stated that the patient was either suffering from mental disorder and/or he/she ought to be detained in the interest of his/her own health and safety or that of other persons. *A treatment order* was similarly signed by two medical practitioners, one from the hospital and the other appointed by the local authority. The duration of the order was for periods of one year, and thereafter for two years. The grounds for treatment admissions were that the patient must be suffering from a mental illness which warranted detention for treatment in the interest of his/her own health and safety and that of others. *An emergency order application* had to be made by a mental welfare officer or a nearest relative backed by a medical recommendation, and it lasted for three days.

(e) Care and treatment

According to the Act, patients must not be ill-treated or wilfully neglected by managers or staff of hospitals or nursing homes. They had to be protected against unlawful sexual intercourse. No restrictions should be placed on the correspondence of patients informally admitted. The correspondence of patients compulsorily detained could be supervised by the responsible medical officer. Letters addressed to the Minister of Health, any member of Parliament, or member of a Mental Health Review Tribunal had to be forwarded in all cases without intervention by the responsible medical officer. Any medical practitioner appointed by the patient or a nearest relative could visit to examine the patient in private, to advise whether an application should be made to the Mental Health Review Tribunal or whether the nearest relative could apply for discharge. The Regional Health Authority and the local authority could send visitors, either medical or lay, to have private interviews with patients. The responsible medical officer could grant any patient leave of absence for up to six months.

(f) Discharge

The discharge provisions of the Act allowed patients to be discharged by managers, the responsible medical officer, or by the Mental Health Review Tribunal. Any patient on a treatment order could be discharged by his/her nearest relative. The nearest relative was required to give the hospital or nursing home seventy-two hours notice. Such a discharge could take place if the responsible medical officer did not certify that he/she would be likely to act in a dangerous manner to himself/herself or others.

(g) Guardianship

A patient could be received into guardianship if he/she was suffering from a mental illness which threatened his/her own health and safety or that of others. The person named as guardian could be either a local authority or any other person, although the order has to be agreed by the local authority.

The 1959 Mental Health Act presented an anti-legalistic approach to mental health care. Judicial intervention through the role of magistrates prior to commitment was dispensed with, and decision-making power was transferred to medical practitioners. The Act saw the introduction of the Mental Health Review Tribunal with jurisdiction to review the application of compulsory admission. Application to a tribunal was restricted in the civil context to patients received into guardianship. This facility was not extended to patients admitted for observation. The Mental health Review Tribunal allowed compulsorily detained patients and their representatives to appeal against their detention and treatment. The Tribunal could decide if the patient should be discharged from hospital.

The intention of the Act was to free all but a few patients from compulsory admission and treatment. A patient could be detained only after efforts to get him/her to enter hospital voluntarily had failed. The Act was a tightrope between the freedom and the liberty of the individual. According to Blom-Cooper (1975), it gave too much power to the medical profession and to Mental Health Review Tribunals. The Act has led to many criticisms and suggestions for reform. The National Association for Mental Health (MIND) and the National Council for Civil Liberties (now Liberty) became increasingly involved in issues of the rights of the mentally ill. MIND's critique of the way the Act works was spearheaded by Larry Gostin, the organization's fulltime Welfare Rights Officer. MIND has campaigned along with professional bodies and has engaged in consultations with the Department of Health and Social Security, as well as participating in intense Parliamentary activity.

Gostin (1975) argued that community care is to be preferred to confinement in hospitals, and no-one should be admitted to a treatment facility unless it has been determined that the facility is the least restrictive setting necessary for that person. He also expressed concern that the 1959 Act made little distinction between the rights of patients admitted informally and those

admitted compulsorily. Informally admitted patients in practice often experienced the same legal restrictions as compulsorily admitted patients, in terms of court access, voting, obtaining a driving licence, sending and receiving post and receiving and using money. Gostin's critique included the procedures for detaining patients compulsorily; Section 29 which allowed a three day emergency admission for observation was, he argued, subject to misuse. He also suggested that GPs and social workers had difficulty assessing psychiatric and psychological states, so that it was questionable whether their decisions could be guaranteed not to infringe a person's liberty. Section 136 of the Act was inadequate as it allowed a police officer to decide if someone was mentally ill, and required emergency compulsory treatment. But the main concern was that most people who entered a mental hospital against their will were given no opportunity to present their case to a Mental Health Review Tribunal. Many who might be entitled to apply to a Mental Health Review Tribunal did not exercise this right, Where patients did apply for a hearing, there was often a considerable delay before a hearing was convened.

The MIND campaign against the workings of the Act aimed to strengthen the patient's legal protection. The campaign took place against a general social background in which there was mounting criticism of the bureaucratization of the Welfare State, which was perceived as stigmatizing and oppressive. The way was now open for legal expertise to be placed at the disposal of clients of the mental health services. This took the form of legal advice, and representation before Mental Health Review Tribunals and in the courts. MIND was a party to those changes, re-orienting its energies towards a more active political role, which culminated in the support of patients' rights, in domestic courts and in the European Court of Human Rights.

A new form of legalism emerged as the underlying philosophy of mental health legislation. The old legalism embodied in the 1890 Lunacy Act was

rooted in repression and a concern for public order. This legalism resulted in the incarceration of the mentally disordered in isolated disciplinary institutions. By contrast, the new legalism reframed psychiatric services in their broader social, moral, legal and political context, rather than seeing them simply in medical terms. Greater legalism in psychiatric detention and treatment was an attempt to encourage patients to accept greater responsibility in decisions affecting their lives, and to improve their status as citizens.

The 1983 Mental Health Act

The 1983 Mental Health Act consolidated the 1959 Act and the Amendment Act of 1982. In the civil context it introduced stricter criteria for compulsory admissions, and a more judicial approach to procedures for reviewing admissions; it strengthened patients' rights to resist unwarranted treatments, offered formal procedures to protect the rights of informal patients, reduced restrictions on patients' civil freedoms, and installed an independent advocacy structure to monitor the delivery of mental health services.

In Section 1 of the Act, mental disorder is defined as consisting of mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind. The category 'mental disorder' is not defined further. It is specifically said that its definition and usage is a matter for clinical judgement, although in practice the category clearly includes the functional and organic psychoses, schizophrenia, depression, mania, dementia and the severe neuroses.

Section 2 is concerned with admission for assessment. Under this Section a person can be taken compulsorily to hospital and be detained there for a twenty eight day assessment period. An application must be completed by either a nearest relative or an Approved Social Worker. There must also be two medical recommendations. One of the recommendations must be made

by a doctor who knows the person. The grounds for admission are that the person is suffering from a mental disorder which warrants detention, and that he/she ought to be detained for his/her health and safety or the protection of other people. This Section cannot be renewed, and the person must be discharged before or on the twenty eighth day, or detained informally, or compulsorily under Section 3.

Section 3 provides for admission for treatment. This is the long-term treatment Section. Patients can be detained for six months in the first instance. A patient can be discharged during the six months, or the detention can be renewed for a further six months. An application must be completed either by an Approved Social Worker or by a nearest relative. Two medical recommendations must be submitted, and one must be by a doctor who knows the patient. The criteria for detention are the health and safety of the patient, the protection of others, and that the patient must be suffering from a mental illness which is treatable, with the proposed treatment being likely to alleviate or prevent any deterioration of the patient's condition.

Section 4 deals with emergency admissions for assessment. It provides a means of compulsory admission for seventy-two hours in an emergency, when it is not possible to obtain the two doctors needed for Sections 2 or 3. An application is required from an Approved Social Worker or the nearest relative. The patient can be discharged within seventy-two hours or a Section 2 or 3 can be used to detain the patient. The Approved Social Worker be trained to provide the specialist assessments required.

Section 5 is concerned with the holding powers of doctors and nurses. The doctor in charge of the treatment of an informal in-patient can detain the patient for seventy-two hours, to allow time for a compulsory Section to be imposed. There is also a new power for Registered Mental Nurses to detain a patient for up to six hours. For the first time the role of the nurse as gaoler is

formalized, thus accentuating the custodial aspect of the nurse-patient relationship.

Most kinds of treatments can be given to any patient with his/her consent. This is similar for compulsory patients. Compulsory treatments, however, except in emergencies, can only be imposed on an unwilling patient in accordance with a treatment plan approved by a psychiatrist appointed by the Mental Health Act Commissioners. Civil patients can appeal to the Mental Health Review Tribunal which has the power to overrule the responsible medical officer and discharge the patient. Patients are granted automatic tribunal hearings without having to appeal. The operations of the Act are overseen by a watchdog body, the Mental Health Act Commissioners. The Commissioners' remit is to protect the rights of detained patients. They can receive complaints, and monitor the use of the Act, and are responsible for providing a code of practice which gives guidance to professionals in respect of informal and compulsory admissions for treatment. Hospital managers are required to give full details to patients and their relatives about the patient's status and rights in hospital.

Social uncertainty, legalism and mental health legislation

Opportunities to make substantive changes in mental health legislation have occurred infrequently in the history of the caretaking of the insane. The 1890 Lunacy Act confirmed and established the principle of legalism, whereby admission to mental hospitals and treatment in those hospitals was governed at all times by statute and controlled by the Board of Control. The 1930 Mental Treatment Act allowed some patients to enter hospital voluntarily without certification. The 1959 Mental Health Act saw the dominance of the medical view of mental disorder and a further reduction of the role of lawyers and the courts. The 1983 Mental Health Act has softened the medical view, provided for a new legalism, and has gone some way to address more overtly the rights of users.

In some ways, therefore, mental health legislation has come full circle from the old legalism of 1890 to the new legalism of 1983. It could be argued that this historical continuity reflects an underlying uncertainty about how society should respond to the challenges posed by mental disorder. The rule of law expressed through mental health legislation serves as a framework for stability in the presence of rival professional interests and philosophical perspectives.

CHAPTER 8

LEGISLATION, CARETAKING AND RIGHTS

This chapter takes a closer look at Parliamentary and public debates about mental health during the passage of mental health legislation in 1930, 1959 and 1983 in order to throw more light on a number of key issues in the history of caretaking work. These issues include conceptions of 'madness', 'insanity' and 'mental illness', the conditions around confinement in asylums and hospitals, the types of treatments available and recommended, the provision of community care, hospital provision and the rights of patients and their relatives, doctors, mental nurses, social workers and other professionals.

The social control of insanity

Forms of mediation and intervention relevant to the mentally ill are connected directly to cultural decisions, social policies and legislation. Underlying the Mental Health Acts of 1930, 1959 and 1983 is a strong sense of a cultural need to control insanity and mental illness by calling on the authority of magistrates, the police, doctors and other health and welfare professionals. Concerns as to who was mentally ill and what should be done about such individuals were expressed in terms of the need to alter or modify certain psychological and physical states. Mental distress was recognized as a social problem which posed a threat to conventional standards of rationality and irrationality. Methods were needed to contain it, along with resources to intervene and control. The distribution of such resources depended on power relations and the attitudes of politicians and professionals. Governments were interested in maintaining the social order. Health and welfare professionals were also bound by vested occupational interests.

As noted in Chapter 7, the 1890 Lunacy Act provided for four types of admissions which were all compulsory and involved doctors and magistrates. The Act concerned itself mainly with safeguarding the liberty of the citizen as

a patient. It did not concern itself with treatments apart from basic physical intervention. Individuals had to pay for hospitalization. The very poor were financed by their local authority, which could mean at times being sent to a remote hospital which was cheaper than one nearer the patient's home (Jones 1960).

Press discussions in this period portray the insane person as someone to be feared and pitied simultaneously. Lunatic asylums were perceived as frightening places in which people were locked up for good. The general view was that insanity was caused by hereditary factors; this view resulted in stigmatization for the patient and his/her family (Ramon 1985). There was, however, one pioneering development which demonstrated a less legalistic approach to providing treatment. This was the Maudsley Hospital which opened in 1915 as a hospital able to take patients without certification (Johnson 1952). **The Times** described plans for the Maudsley in the following terms:

'We are glad to be able to place before our readers some details of a scheme which has just been formulated by a committee of experts, acting on behalf of the London County Council, for establishing a new hospital in the metropolis for the treatment of the insane, and a hospital moreover, which is intended to be something more than a mere place of refuge for the treatment of individual cases of lunacy, the object in view being to make it also supply, what has long been a great want in medical science, the provision of a school for the scientific study of insanity with a thoroughly experienced staff of visiting physicians. The system under which lunatic asylums have hitherto been conducted is one which has tended more to administrative efficiency than to scientific study, and it is obvious that if a hospital could be founded in London for the study of

insanity as a disease as well as for the cure of its patients a great benefit would be secured to the whole civilized world. Happily the committee have gone about their work in a thoroughly business-like spirit. They have not confined themselves to theoretical dreaming, but have applied themselves to practical details.

They estimate the cost of erecting a hospital with 100 beds at £32,000, and consider that the annual expenditure for the maintenance of the institution, the fees of visiting staff, the interest on capital (including that expended on the purchase of a site), and so on would not exceed a sum of between £8,000 and £10,000'. (**The Times** 27.1.1890:13c).

Other press reports at the time took up the issues of scientific developments in the treatment and cure of the insane; growing concern about the use of mechanical restraint in caretaking work; and the development of bodies which questioned existing provisions for lunatics. For example, on the question of mechanical restraints, the following appeared in **The Times** in May 1890:

'The Lunacy Act 1890. The local Government Board have forwarded to Boards of Guardians copies of a regulation which has been made by the Commissioners in Lunacy, under the Lunacy Act 1890, as to the use of mechanical means for the restraint of lunatics. The regulation states that the intention of section 40 (6) of the Act obviously is to discourage the employment of mechanical restraint in the treatment of the insane, except in cases of manifest and urgent necessity, an object which the Lunacy Commissioners has always endeavoured to promote. It is with great reluctance, therefore,

that the Commissioners approach the performance of the duty imposed on them by the legislature of determining the instruments and appliances of restraint, and their discharge of the duty must not be construed as implying any greater countenance by them of this mode of treatment than they have hitherto given to it. They recognize that cases will occur in which it is necessary for the safety of the patient or of others, or is beneficial to the patient, that mechanical restraint should be applied; but they hold that the application of it should be restricted within the narrowest limits possible, that the restraint should be applied by means the most humane that can be contrived, should not be long continued without intermission, and should be dispensed with immediately it has effected the purpose for which it is employed. The Commissioners direct that at each visit of the Commissioners or a Commissioner to an asylum, hospital, or licensed house, or to a single patient, all instruments and mechanical appliances which may have been employed in the application of bodily restraint to a lunatic since the last preceding visit of Commissioners or a Commissioner be produced to the visiting Commissioners or Commissioner by the superintendent, resident medical officer, or resident licensee or the person having charge of the single patient' . (**The Times** 3.5.1890:8f).

A few days later, **The Times** highlighted moves towards lunacy reform:

'Lunacy Law Reform. A conference of ladies and gentlemen was held under the auspices of the Lunacy law Reform Association at Mr. George Russell's residence, 18 Wilton Street, yesterday. The object of the conference was to consider the effect of the Lunacy Acts Amendment Act, which came into operation on the

1st inst. The conference especially desired to draw public attention to several points which it regarded as of supreme importance. The conference unanimously agreed that reformers should aim at the gradual extinction of all private asylums kept for gain and the substitution for them of paying wards in public asylums on the model of St. Thomas's Home connected with St Thomas's Hospital. It was also agreed that the Lunacy Commission should be abolished as hopelessly effete, and its functions transferred to local representative bodies'. (**The Times** 8.5.1890:12b).

Against this background, Parliament appointed a Royal Commission on Lunacy and Mental Disorder on July 25, 1924. The Commission's terms of reference were wide: they were to enquire into: 'The existing law and administrative machinery in England and Wales in connection with the certification detention and care of persons who are, or who are alleged to be of unsound mind, and also into the extent to which provision is or should be made for the treatment without verification of persons suffering from mental disorder'.

Debates at the time of the 1930 Mental Treatment Bill

The 1930 Mental Treatment Bill was initiated in the House of Lords in November 1928 by Earl Russell. In the Commons the Bill was introduced on December 23, 1929, by the Rt. Hon. Arthur Greenwood. In the second reading of the Bill, recorded in **Hansard** (Hansard 235:958-1010) a number of concerns were apparent. The Minister of Health, Mr. Greenwood said:

'There is emphasized the view that there should be early treatment, and that mental disease should be viewed much the same way as we now view physical disease...If we accept the view of mental disease, not as a visitation of Providence, not as

something indecent, about which we ought not to talk in public but as something in the same category as other forms of human ailment, then it becomes quite clear that the community ought to organize its resources to enable us to carry out preventive measures and early treatment' . (Hansard 235:958).

Mr. Leif Jones pointed out that:

'The duty is laid upon every local authority to provide and maintain suitable accommodation for temporary patients. Will not that mean that every local authority will have to make provision for a new class of patients, and will not that involve a very considerable expense to local authorities?' (Hansard 235:965).

And Mr. Stephen replied that:

'There will be additional expense, and is there not going to be some additional provision made by the National Exchequer in order to relieve the local authorities to some extent?' . (Hansard 235:966).

These Parliamentarians were reflecting prevailing changes in medical thinking about the nature of mental illness. At this time the legalistic and moral approach was giving way to the clinical-somatic approach. Mental illness was seen as a disease with physical causes; therefore, it could be treated and cured like any other physical disease. Because it was a disease, it was to be treated by doctors. According to Ramon (1985), this approach emphasized diagnosis of the disease and treating it rather than attempting to understand the whole person and his or her environment. The large Victorian asylums suited this approach. Psychiatry was used to contain people, despite

recognition of its weak knowledge base in intervention techniques. Now psychiatry was saying that these illnesses could be diagnosed and cured (Scull 1979). Much of this new assertion in psychiatry came from the work of Wagner-Jauregg, the Austrian neurologist who received a Nobel Prize in 1927 for his work on the use of induced fevers in treating mental illness. The major implication of Wagner-Jauregg's work was that mental illness could have a single physical cause which medical research could locate and control (Sim 1969). These developments appealed to doctors, lay persons and nurses, as they offered a neat explanation and gave prestige to general medicine (Ramon 1985). It could be argued that those outside medicine found the new medical explanations acceptable, because they had no alternative systematic theories to put forward. Mr. Greenwood pointed out that:

'Today if the medical practitioner is made defendant in a case for wrongful certification the onus of proof rests upon him to show that he has acted in good faith and with reasonable care. I think it is clear that we cannot completely remove responsibility from medical men. After all he has made a decision and, therefore, whilst we must keep upon him a certain measure of responsibility it is important on the other hand that he should have reasonable protection against cases which might be brought and which might mean his financial or professional ruin, even if the case did not go against him'. (Hansard 235:969).

This concern was shared by both doctors and politicians; it symbolizes the status and equality which psychiatrists wanted with other doctors. The protection which the psychiatrists wanted was that no civil or criminal proceedings could be brought against them in any court in respect of their work with patients without the leave of the High Court. Further, that High Court should not be allowed to give leave unless it was satisfied that there were substantial grounds, and the doctor had acted in bad faith. This device

was seen as protecting the autonomy of clinical-professional judgement, with the assumption being that professional knowledge offered an improvement on the commonsense view, although this might not be accepted by everyone.

A further important point was the Poor Law aspect. Members of Parliament were concerned that mental illness should be removed as a category within the framework of the Poor Law, so that the mentally ill would no longer be stigmatized in this way. Dr Morris-Jones offered that:

'It gives the poor something of the chance of the wealthy for the first time in regard to lunacy. it changes the word "pauper" into "rate-aided patient"; and it substitutes for the words "lunatic asylum" the words "rate-aided mental hospital"' (Hansard 235:987).

In the same debate, Dr Ethel Bentham pointed out that:

'Another reason is that seven-eighths of the people who are certified have to go through the Poor Law, and there is a horror of the way in which they are treated, although I do not believe they are badly treated intentionally, but the circumstances surrounding their reception are such that it is no wonder people do almost anything at avoid disclosing insanity' (Hansard 235:988).

The question was raised as to whether magistrates or doctors should be involved in the admissions process. Dr Morris-Jones said:

'This clause abolishes for the first time in this country, the judiciary, as it were, in dealing with mental patients. My own view is that the intervention of a magistrate in this sort of case is unnecessary and may even be harmful'. (Hansard 235:985).

There was a broad consensus that only doctors should be party to the admission process. Magistrates were thought of as lacking the relevant knowledge, and suffering from the disadvantage that they would stamp the stigma of criminal procedures on hospital admission. This preference for the professional's judgement over that of the lay person was a move away from the tradition of regarding magistrates as the main safeguard of the lay person. It was possible because psychiatrists were at the time explaining insanity in terms of physical disease, which made them the only professionals capable of diagnosing, treating and curing insanity.

In the Parliamentary debates of the time, Members wanted to see the temporary and voluntary admission of patients, with certification only being used when absolutely necessary. Temporary patients were deemed to be persons suffering from a mental illness, and likely to benefit from temporary admission, but incapable of expressing themselves as willing or unwilling to receive such treatment. The intention was to provide for cases such as problems after childbirth and alcoholism, where relief of the associated physical condition might be expected to produce an improvement in the mental condition in a short period of time. Voluntary patients were any people wishing of their own accord to submit themselves to admission to a mental hospital, nursing home or observation ward in a general hospital. Early hospitalization was seen as necessary if the mentally ill was to benefit from the system. Mr. Greenwood put it in the following terms:

'The cases we keep particularly in mind are the cases of the man whose mind has been temporarily broken by overwork, the cases of women in childhood who suffers from puerperal mania, and cases where with proper treatment fairly early recovery might be expected. Think of the woman after confinement whose mind becomes temporarily unhinged and who is branded with the stigma not only of the Poor Law but

certification' (Hansard 235:961).

There was a tendency to blame the Board of Control for mishandling the mentally ill and their relatives and causing public mistrust in the profession. There was a feeling that the Board of Control was too remote; even doctors could not gain easy access to it. Dr Ethel Bentham said:

'The third thing which makes people so nervous of disclosing insanity in the family is the mysterious and awful Board of Control. I may say that I have been for 13 years a general practitioner and have acted as a justice under these Acts ever since women magistrates were first appointed, and so I have had considerable knowledge. When in the interest of a patient, I have had to go to the Board of Control, I have found it human - when you could get at it. But it is a mysterious board. People do not know of its name or how to get at it'. (Hansard 235:991).

A complementary view was expressed by Sir D. Newton:

'It seems to me that the powers of the Board of Control are too far reaching. The duties of the Board of Control are to protect the liberty of the subject and to say whether in the public interest a man should be detained. It should not be the duty of the Board of Control to interfere with local government, and possibly to override the wishes of the elected local government representatives' (Hansard 235:993).

Concerning the protection of the patients, Members suggested that patients needed protection first against themselves, and also in many cases against their relatives. As Dr Ethel Bentham illustrated the point:

'I knew a case, a good many years ago now, of a man who had been discharged from a lunatic asylum. On the second morning after his discharge a lady calling on him went into his house. It was in one of those northern towns where the doors are always on the latch, and she walked in just in time to prevent him cutting his throat. She had the presence of mind to say, "not there man, not there; come over to the sink. Think what a mess you will make!" That saved him. Only two days before that man had been discharged from an asylum, supposed to be cured. In many cases the people who look the best are possibly those least able to be trusted by themselves' . (Hansard 235:989-990).

Dr Bentham was a magistrate as well as a doctor, yet she was critical of doctors and the available knowledge on mental illness diagnosis and treatment, and suggested that magistrates, because of their class background, might not be able to communicate effectively with all classes of patients.

On February 18 1930 an article appeared in the Times which outlined the main provisions of the second reading of the Mental Treatment Bill. This Bill provided details of the reception of voluntary patients, the establishment of outpatient clinics and the prohibition of marriage among patients classified as mentally defective (**The Times** 18.2.1930:8d). Concerning the reception of voluntary patients, reports in **The Times** (19.9.1930) pointed out that for the first time the new Act authorized the reception of voluntary patients into public mental hospitals, and defined the conditions under which they could be treated. Attention was drawn to the provision for temporary treatment of patients on the recommendation of two medical practitioners without the intervention of any judicial authority; it was noted that this provision marked a striking advance in the assimilation of the treatment of mental illness to that of physical illness; voluntary patients were not limited to being treated in public

mental hospitals, but could be treated in any institution or hospital. The report suggested that patients could benefit from being treated in both non-teaching and teaching hospitals large enough to have wards for patients suffering from nervous and mental disorder. Further, the report claimed that in the case of teaching hospitals, such an arrangement would be of special value, not only from the point of view of the patient, but in the interests of medical education and research. With regard to outpatient clinics, local authorities were now empowered to provide these and to make suitable arrangements for aftercare and to undertake research.

The issue relating to the prohibition of marriage was related mainly to mental defectives and not the mentally ill. Here the report stated that:

'...the prevention of marriage between mental defectives would be a preventive measure of great social utility. Not only would it draw public attention to the unwisdom of allowing defectives to marry but it would place local authorities in a far stronger position by enabling them to insist on proper precautions being taken by the persons to whom defectives are licensed and by their parents and guardians'. (**The Times** 19.9.1930:12d).

A few months earlier, in July, **The Times** dealt with the new roles and responsibilities which the 1930 Mental Treatment Bill would place on local authorities in a report of a conference held in London of representatives of local authorities. The issues highlighted related to the changes brought in by the Act for the reception of voluntary patients, which the delegates agreed would mean a more humanitarian and scientific approach, geared to enabling curative measures to be adopted in the initial stages of mental disturbance. They also saw the establishment of outpatient clinics as long overdue, but expressed concerns as to how local authorities would be able to meet the costs of these. Mr.I.G. Brooks, the Conference chairman, said that:

'... there was no need for apprehension that the voluntary patients were going to cost local authorities a lot of money. The great bulk of the patients they were going to treat on a voluntary basis would, under the old dispensation have become certifiable. It was more economical to get the patient first and treat the case when it was still hopeful'.

(**The Times** 23.7.1930:9c).

In August 1930 **The Times** carried a brief report about a committee appointed by the Board of Control. The Board had taken over from the Commissioners on Lunacy the monitoring of the system of care provision for the mentally disturbed, and had set up a committee with the following terms of reference: 'To consider and advise what principles should be observed in the approval by the Board of Control the medical practitioners for the purposes of Section 1,(3) and 5,(3) of the Mental Treatment Bill' (**The Times** 21.8.1930:7d). Section 1 of the Act dealt with the power to receive voluntary patients and subsection 3 with the medical recommendation in the case of persons under the age of 16. Section 5 dealt with temporary treatment without certification, and subsection 3 with medical recommendation.

A letter to the Editor of **The Times** noted that all of this signified the start of a new era in the treatment of the mentally ill:

'... the Mental Treatment Act... registers, so to speak, the birth of a new attitude of public opinion on the treatment of the mentally afflicted...The significance of the new epoch consists in the fact that the Mental Treatment Act, without abandoning certain legal safeguards still considered necessary for the protection of liberty, makes effective provisions for mental disorders on the basis of relegating legal certification to the position of the last rather than the first step in arrangements for the medical care of afflicted persons' . (**The Times** 22.9.1930:8b).

This letter went on to note that this development coincided with the provisions of the Local Government Act which put the whole administrative machinery for the ascertainment, prevention, and treatment of all forms of disease into the hands of local authorities, practically without limit or restraint. Lunacy was part of the total scheme. The net result was that, 'The Medical Officer of Health's department will become a continuously operative laboratory of investigation into the sources of disease, bodily and mental'.

These reports brought to public attention a number of important points. The main ones were: the new roles and financial costs for local authorities in making outpatient clinic provision; the emphasis in the new Mental Treatment Bill on the *scientific* study of lunacy, the provision of humane treatment and the search for cures; the possibility for voluntary admission of patients; the removal of magistrates from the admission process, and the use of two doctors' recommendations for all admissions; and the admission of lunatics to teaching hospitals.

In the eyes of Members of Parliament, doctors dominated the professional scene, but some Members were also concerned about the conditions of mental nurses' work. The nurses were the largest workforce in the asylum system. They worked under difficult conditions, and these featured in the Parliamentary debates both as aspects of their work of the generally poor environment provided for the mentally ill (Hansard 232:1644 and 232:980). On the whole, according to Ramon (1985), the nurses tended to accept the doctors' views and saw themselves as auxiliaries to the doctors. Their social control function was taken for granted by both the hospital administration and the mental nurses themselves.

Only a minority of Members participated in these debates. Most of these were on the political left. The politicians opted for the strengthening of the dominance of clinical-somatic psychiatry, rejected the role of magistrates,

questioned the power of the Board of Control, extended voluntary admission and required local authorities to provide more services for the mentally ill.

Debates at the time of the 1959 Mental Health Act

On October 22 1953 Parliament announced a Royal Commission on the Law Relating to Mental Illness and Mental Deficiency; the aim was to look into the processes of certification and detention of persons in mental hospitals. The terms of reference of the Commission were as follows:

'To enquire, as regards England and Wales, into the existing law and administrative machinery governing the certification, detention, care (other than hospital care or treatment under the National Health Service Acts 1946-52), absence on trial or licence, discharge and supervision of persons who are alleged to be suffering from mental illness or mental defect, other than Broadmoor patients; to consider, as regards England and Wales, the extent to which it is now, should be made, statutory possible for such persons to be treated as voluntary patients, without certification; and to make recommendations' (Royal Commission on Mental Illness and Mental Deficiency 1957).

The evidence of this Royal Commission laid the foundations of the Bill which was debated in Parliament in 1958 and 1959. The Queen's speech in October 1958 stated that:

'Effect will be given to many of the recommendations of the Royal Commission on mental illness: and the provision of a new Bill will replace the existing law on mental health in England and Wales' (Queen's Speech Hansard 594:6).

The 1959 Mental health Act came within the framework of the National health Services Act of 1946. It repealed the 1890 and 1930 Acts. The severely subnormal and the mentally ill were both provided for in this Act. The Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency stated that the Mental Treatment Act was far less coercive than the Mental Deficiency Acts. The Commission argued that the Mental Deficiency Acts resulted in a high reliance on compulsory treatment. The National Society for Lunacy Reform and the National Council for Civil Liberties supported the Commission's views. In the light of these comments, the Government decided to cater for these two conditions in one Bill. The use of a single Act for both the severely subnormal and the mentally ill involved the belief that the two conditions, though medically and socially different, could be treated as one in law. Psychopathic patients were recognized as a separate category for the first time, and the question of defining this group was left to the medical profession. The Board of Control was abolished, and a new body to which appeals could be made was established as the Mental Health Review Tribunal. Community care and guardianship were introduced to offer support to the people who were discharged from hospital and to relieve the pressure on beds.

By the end of the 1940s it was generally known that psychiatric hospitals were overcrowded, with inadequate recreational facilities and staff. In 1954 **The Lancet** carried an editorial which was concerned with the suggestion that mental nurses should be paid 'danger money' because the difficulties which they faced were caused by the conditions of the hospitals. Mental hospitals lacked sufficient staff - both nurses and doctors. There were no established posts for doctors; for nurses there were established posts, but there was a shortage of new recruits, and new entrants were leaving before completing their training. Other factors contributing to the shortage of mental nurses were low wages, and the low status of the work generally and in relation to general nursing. Mental nurses were dissatisfied with the non-co-operative nature of

their relationships with doctors, the hierarchical structure of nursing and hospital organization and the menial tasks which they had to perform. Training was another area of concern. Out of a period of three years training, fifteen months were devoted to general nursing and the relationships between the tutors and the senior mental nurses on the wards were strained (**Nursing Mirror** 1954:12 & 354-452). Some argued that the technical skills employed by mental nurses in the giving of ECT should go some way to demonstrate their knowledge and status (**Nursing Mirror** 1957:xiii-xi). The high percentage of male mental nurses resulted in a high proportion of mental nurses belonging to a trade union, and this probably confirmed the arguments of the general nurses that mental nurses were not professionals. General nurses saw mental nurses as doing domestic jobs, performing work which, apart from ECT, required few technical skills, and belonging to trade unions which were not perceived as professional associations (Ramon 1985).

Mental nurses were, however, taking on more of the jargon used by doctors and psychiatrists, and were seen by some as professionals working as part of a team. Their position reflected the growing division within mental nursing, between those who saw themselves as doctors' assistants and those who saw themselves as social therapists. With the former view went a concentration on physical treatments, and uncritical acceptance of mental hospital rules and the passivity and dependence of patients. The view of mental nurses as social therapists saw them as key figures in the rebuilding of relationships between patients and the social world. Such nurses were mindful of the associated physical condition of patients and the physical treatments available, but were willing to give up the traditional professional distance between patients and themselves, and sought to encourage patients to change their attitudes to themselves and the social world.

The Parliamentary debates of the time recognized that there had been changes in psychiatric treatment and practice, and these practices they saw

as improvements. The Minister of Health, the Hon. Derek Walker-Smith, in his opening speech at the second reading of the Mental Health Bill on January 26, 1959, expressed it thus:

'The legislation which we now repeal marks, of course, a great advance... Research in many fields has a bearing on psychiatry. From psychology and the work of pioneers like Freud there has come a better understanding of how the mind works and why people behave as they do...In the hospital, the use of physical treatments such as insulin, Electro-Convulsive therapy, leucotomy and drugs have made hitherto withdrawn patients accessible to rehabilitation through treatments such as group therapy, organized occupation, and the 'open door' principle. Complementary with this advance, and in no small degree due to it, there has been a parallel and most welcome advance in the public attitude to mental disorder. The position today is this. Our code of law and procedure, mainly fashioned for an earlier day, is out of phase with our advance in medical skill and public understanding' (Hansard 598:707).

Any new treatment which freed patients from chains and solitary confinement was welcomed. The new drugs and ECT which started to be used extensively after the 1930s were accepted as generally a good development. Clare (1976) has pointed out that electricity has a long history of being associated with the treatment of the insane. Such developments placed doctors in a very dominant position in the mental hospital, where there were few critiques of the new treatments. At the same time, the caretakers' role and function changed to emphasize more their functions as doctors' assistants. Individuals such as Dr Johnson raised in the House the issue of the harmful effects of ECT and psychosurgery, but such queries were not generally treated seriously (Hansard 594:820).

It is also clear from Parliamentary debates at the time that most MPs saw voluntary admission as a major achievement. Compulsory admissions would only be used for a residual category of cases in the interest of society and in the interest of the patients themselves. MPs saw this situation as carrying a greater measure of citizen rights and also personal dignity, and resulting in less stigmatization for both patients and their relatives (Hansard 573:85).

Barton (1959) argued that the favourable assumption of voluntary/informal admissions might have another side to it: that people went into hospital through persuasion by relatives and professionals rather than because of their own wishes, and that they might sometimes stay in hospital because of a lack of alternatives and a hostile social environment, rather than because they found their hospital treatment helpful. Parliament was concerned that people were being hospitalized as a result of misapplied diagnoses and misjudgment by professionals. One example was the Thornton case. Mrs Thornton was a middle-aged woman with a history of marital difficulties and a keen believer in spiritualism. At one point, she was referred by her General Practitioner for a psychiatric evaluation because of what seemed to be paranoid fears and complaints about her husband. The psychiatrist suggested that she was in need of a solicitor's advice to sort out her marital problems. Later she complained about a murder attempt by her husband and was compulsorily admitted to a psychiatric hospital and diagnosed as suffering from paranoid hallucinations. When the case was examined further, her complaints were found to be real. Her husband had attempted to push her over a bridge, and was stopped by a local policeman. Mrs Thornton was then examined and her discharge was recommended. This case was used by MPs as an example of the many people who were unnecessarily in hospital and the lack of concern over the harm done to such people. The House was informed by Dr Johnson and Mr Dodds of allegations of professional misjudgments and misconduct which patients had submitted in writing to them (Hansard 605:932). Dr Broughton said:

'Another case which I wish to quote is that of a woman of thirty who had a great deal of domestic worry and trouble causing her to be depressed. She had neglected herself, eating little, drinking too much and losing a great deal of weight. She became stuporous and resisted all attention. She was certified and brought into a mental hospital. On examination she was found to be suffering from pneumonia. She died within two days and the post-mortem examination showed a massive low-grade pneumonia. Her mental condition had been due to her general debility and toxæmia from pneumonia' . (Hansard 573:79).

The majority of MPs rejected the possibility that this state of affairs reflected badly on professional practice. Even the likelihood of a mistaken diagnosis was dismissed. Mr Sorensen, for example, said:

'I admit that there is a possibility of error, but as a result of twenty-one years' close association with one and some contact with three mental hospitals and of membership of a mental hospital committee, every fortnight visiting the wards and the patients, talking to doctors and relatives, and after a great deal of discussion with mental patients today and having met those who have been in hospital and are now discharged, all I can say is that any idea that there is gross ill-treatment or unnecessary detention of vast numbers of patients is quite untrue. The sooner we make that clear, the better for the sake of the patients themselves and their relatives'. (Hansard 573:89).

Members were inclined to blame the lack of resources, poor accommodation, staff shortages, overcrowding, inadequate staff training and the shortcomings of the Board of Control. As Dr Johnson said:

'Rightly or wrongly, it is the custom for criticism of our health and welfare services at present to be expressed in somewhat muted tones. Therefore, it is natural and proper that when we come to the recommendations of the Commission for the abolition of the Board of Control...I, on the other hand, will be sending no orchids to the obsequies of the Board of Control. It has outlived its usefulness in the manner which has already been stated by my right Hon. friend the Member for Thrisk and Malton (Mr.Turton)' .(Hansard 573:89).

Some MPs attacked the government for allocating too few resources to the psychiatric services. 'Cinderella of the NHS' was the term employed to describe the situation in which resources were inequitably allocated (Hansard 573:81). Dr Broughton described the situation thus:

'Hon. and right Hon. Members speaking today have put their fingers in the various bad spots, drawing the attention of the Minister - if indeed it needed to be drawn, as I think he is already aware of it - to the need for improvements in this field of medicine, but I think it is a fact that psychiatry is the Cinderella of the health service. It is quite ridiculous that it should be so, because half our hospital beds are occupied by patients with mental illness and it is probably true to say that as many as 75 per cent. of patients who go to visit their general practitioner are suffering from some form or other of psychosomatic illness'. (Hansard 573:81).

The proposal to establish a Mental Health Review Tribunal was welcomed by the House. This tribunal would replace the Board of Control as the body to which appeals could be made. As Dr Broughton pointed out, access to the tribunal would be possible only after hospitalization:

'There is no provision for the patient to be heard or to be seen by anyone other than the doctors and the applicant. His sole right is that of appeal to the Mental Health Review Tribunal after the detention has commenced. This is the greatest weakness of the Bill and it is clear that the safeguards are quite inadequate. I have attempted to explain to the House why I feel unhappy about this part of the Bill, which deals with compulsory detention, and I am grateful to you, Sir, and to the House for bearing with me while I express at such length my doubts and fears'. (Hansard 605:418).

As noted in the last chapter, Membership of the Mental Health Review Tribunal panel included a psychiatrist, a lawyer and a representative of the public. This planned composition was not questioned, despite the fact that representation of members of the public on such bodies tended to be drawn from the employed, able-bodied middle class. Moreover, Tribunals could withhold information from patients and could prevent them from attending the hearing. Some members felt that patients would not be treated as equal participants in the review. Mr Dodds drew the attention to the neglect of patients' own perspectives:

'What astonishes me is the faith which we have in the Mental Health Review Tribunals. I have said previously that they are a wonderful piece of machinery which, I feel, will do a great job. One feature however, has been missing from our debates. It seems to me that there has been a lack of knowledge of the experience of patients'. (Hansard 650:454).

Some MPs pressed for more patients' rights and wanted Tribunals to be truly independent. Mr. Turion said:

'The Mental Health Review Tribunals are an excellent idea, but I hope that the Government will not follow the suggestion made in paragraph 447 that the clerk to the tribunal should be a regional officer of a central department or an officer of a regional hospital board. We know quite well that the average citizen looks upon a tribunal of any kind very much in the light of where its office is. Here we are dealing with an appeal against a decision of a medical superintendent in a hospital appointed by a regional hospital board. Consequently, the officers of the tribunal should not come from the office of the regional hospital board'. (Hansard 373:67).

The overall impression of these debates is that MPs welcomed the Mental Health Review Tribunal but left the principles for its implementation very much up in the air.

An important development which took place with the passing of the 1959 Mental Health Act was the inclusion of 'psychopathic personality' as a category added to the diagnostic list of psychiatric disorders. Although there was no clear working definition, doctors were expected to be able to make this diagnosis. While accepting that the definition of psychopathic personality was subjective, Dr Summerskill endorsed Professor Henderson's (1939) definition:

'The fact is that the judgement of who is a psychopath is subjective and not objective. It is determined in part by certain conventions recognized in the society of the doctor and the patient. Perhaps I may give as an example what comes to mind as I look at the windows, although I know that in this House one is not expected to draw attention to anything which is not in the Chamber. The windows above once had a grill in front of them.

Let us imagine what might have happened in those days had this recommendation been implemented and it was necessary to decide what should be the future destiny of an individual who might have been arrested. Imagine that a woman who had been brought up in a comfortable home had decided, because she felt strongly about the suffrage movement, to go out of her home, to fight with policemen and to undergo forcible feeding again and again. In the light of all this, it might have been possible for a psychiatrist, who himself perhaps, had certain emotions and certain views on feminism, to say, for a woman with that background to do this, there may be a streak of subnormality. That is an example of what might happen in the past. I might say that many of those women who underwent that fearful fight in the suffrage world are now very normal elderly ladies whom I occasionally see and who show no signs of mental disorder. Nevertheless, to illustrate my point, it might be possible that a psychiatrist would say that there might be a streak of abnormality in one of these women. If the psychiatrist is uncertain whether an individual has a psychopathic personality, how will a prison medical officer and a general practitioner always be certain of making accurate diagnosis? It was in a lecture by Dr. D.K. Henderson, a professor of psychiatry at Edinburgh, twenty years ago, that I came across what I should have liked to see something like this included in the Report. Dr. Henderson describes psychopaths as; those individuals who conform to a certain intellectual standard, sometimes high, sometimes approaching the realm of defect but not yet amounting to it. who, throughout their lives or from a comparatively early age, have exhibited disorders of conduct of an anti-social or asocial nature, usually of a recurrent or episodic type, which, in many instances, have proved difficult to

influence by methods of social, penal and medical care. It is for this reason that I speak so strongly. My feelings that civil liberties should be maintained is such that I would prefer many psychopaths to escape rather than that one individual should be deprived of his liberty' .(Hansard 573:48-50).

Dr Summerskill's warning concerning the dangers of identifying non-conformity with psychopathy was taken up by Baroness Wootton in the House of Lords (Hansard 217 Lords 393-395). She objected to the over-generalization embedded in the term 'psychopathic personality'. Despite these protestations both Houses saw the inclusion of the category as a positive step in a more humane direction. Thus psychiatrists entering psychopathic personality as an official diagnostic classification of mental illness showed an example of psychiatry in the service of social control, where a potentially disruptive group of people was to be taken care of clinically and administratively.

In January 1959 **The Times** carried an article which reported the changes recommended by the Royal Commission on Mental Illness and Mental Deficiency May 1937, and were proposed in the forthcoming Mental Health Bill. It went through the ways in which the new Bill would take account of advances in medical knowledge, and the changes in the organization of social services since the Lunacy Act of 1890, the Mental Deficiency Acts between 1913 and 1938 and the Mental Treatment Bill of 1930. It was stated as a real advance that the new Bill would replace this legislation with a single legal code which would cover both mental illness and mental deficiency (**The Times** 6.1.1959:4c).

In March, **The Times** reported that magistrates welcomed the new Bill now before Parliament, and that the Council of the Magistrates' Association believed that both patients and the public would be better served under the

new suggested procedure of two medical recommendations for compulsory admission, rather than the prevailing system of medical and magisterial certification (**The Times** 10.3.1959:6c). In April, there appeared a brief note reporting that the Minister of Health intended to issue a formal direction making it a duty for local authorities to provide mental health services. Lord Pakenham protested that the new Bill did not go far enough. He called for the insertion of a mandatory and statutory duty on local authorities, and said that an adequate allocation of funds must be made to them (**The Times** 27.4.1959:15a). This was followed by a report on the frequency of the right of access to the Mental health Review Tribunal. It was argued that compulsorily admitted patients should have access to the tribunal at least once in every two years (**The Times** 6.5.1959:6f).

In June **The Times** carried a report of the debates on the second reading of the Bill in the House of Lords. There was general agreement that the new Bill would be in keeping with medical and social advances, and that the Bill would result in completing the processes of administrative integration of the mental health services into the National Health Service (**The Times** 5.6.1959:6c). Later the same month it was reported that the new Mental Health Act would clarify the definition and classification of mental disorders. Also reported was the debate in the House of Commons about the development of community care and the role and responsibilities of local authorities (**The Times** 24.6.1959:14a).

To summarize, these media reports were concerned with five main themes: the proposals of the 1959 Mental Health Act which would repeal and replace all the Bills since 1890, instituting instead one Bill to cover both mental illness and mental deficiency; the need for the 1959 Mental Health Act to state the duty of local authorities to provide services; the right of compulsorily admitted patients have regular access to the Mental Health Review Tribunal; the administrative integration of the mental health services into the National

Health Service; and the 1959 Mental Health Act's clarification of the definition of mental disorders.

Debates at the time of the 1983 Mental Health Act

Between 1959 and 1975 there was one ministerial paper relevant to the provision of mental health services (Ministry of Health 1962). This paper, entitled **Health and Welfare: The development of community care**, addressed the desirability of community care for psychiatric patients. The paper was published at the same time as the work of Goffman (1968) was highlighting the impersonal and self-serving machine aspects of institutions. According to Goffman, this situation resulted in many long stay patients in mental hospitals having two illnesses: the one which caused their admission, and one given them by the institution itself. The paper lacked directives for the actual practice of community care, however, and there was little investment in training and in the provision of sufficient social workers and community nurses. In 1975 the white paper, **Better Services for the Mentally Ill** was produced as a part of the plan for restructuring the NHS. At the same time there were criticisms of the 1959 Mental Health Act. This Act was by then widely seen as attaching moral blame to the individual and punishing him/her with the loss of liberty and other rights as a citizen.

Media discussion and Parliamentary debates were concerned with the prospects of the Mental Health Amendment Bill ensuring that fewer mentally handicapped people would be locked up in hospital, and enabling the mentally handicapped to challenge their detention; the reactions of psychiatrists to the proposal that patients should be given more rights, and that other professionals should be included in discussions concerning treatment; the suggested new treatment rules whereby treatments considered to be irreversibly and hazardous would require the psychiatrist to consult with two other professionals before administering such treatments; and the difficulties patients have in getting their voices heard, both within and outside

mental institutions.

In January 1982 **The Times** drew attention to the issue of aiding the mentally handicapped by ensuring that fewer of them would be locked up in hospitals. The article described Mr Brian Rix, the former actor who runs the charity Mencap, as saying, 'We would have liked separate legislation, but we have got 85 per cent of what we want'. He further commented that the Amendment would enable the mentally handicapped to be able to have their detention challenged (**The Times** 14.1.1982:24d).

A psychiatrist, Dr John Hamilton, delivered a critical view of the Mental Health Amendment Bill in February 1982. Hamilton was reported by **The Times** as arguing that:

'The Bill now passing through Parliament was intended to give patients better rights but paradoxically if enacted as it stands, it is likely to lead to poorer treatment and patients will suffer more and become prisoners of their illnesses' (**The Times** 21.2.1982:19c).

In March the topic was the debates on the Amendment Bill concerned with decisions for irreversible and hazardous treatment. In response to the comments of Lord Winstanley and Lord Hooson, MPs agreed that, instead of the practice under the 1959 Mental Health Act where only a psychiatrist decided, two lay people as well as a psychiatrist should make decisions in cases of irreversible and hazardous treatments (**The Times** 4.3.1982:2a).

The medical director of Broadmoor special hospital for mentally abnormal offenders, Dr Edgar Udwin, argued that the Mental Health Act Amendment Bill's proposal that a second medical opinion should be given when a patient refused drug treatment could hinder the patient's treatment. In the same

report, MIND commented that the law on the censorship of patients' correspondence should be changed to allow for the scrutiny of incoming mail only (**The Times** 23.4.1982:6f).

Some psychiatrists were opposed to proposals which required them to obtain a second opinion before administering drugs to a non-consenting patient detained in hospital under the Mental Health Act. According to the Royal College of Psychiatrists,

'... many psychiatrists strongly believe it was too restrictive to require a second medical opinion, and that it would cause many difficulties in treating patients, especially in the prescribing of commonly used drugs which were often given without delay'.

Mr Christopher Price questioned these views in the light of recent inquiries which had criticized the over-use of tranquillizers and the irreversibility of some drug treatments.

(**The Times** 28.4.1982:2c).

Some of the media reports referred to actual case-histories. In April 1982, **The Times** discussed an incident in the House of Commons when evidence was given to the Standing Committee on the Mental Health Amendment Bill. A schizophrenic patient, Mr Figura, was detained under section 26 of the 1959 Mental Health Act and was brought before the Standing Committee by MIND. Mr Figura said that he had been given ECT and medicate without his consent after he had complained about the hospital food. He also claimed that no staff member or social worker had discussed his treatment with him, and that he trusted none of the hospital staff. The then Minister of Health, Mr Kenneth Clarke expressed doubts as to whether the patient's evidence should be accepted at face value. His comment brought objections from other members of the committee who took the view that all witnesses should be treated alike

and their evidence not impugned. One member of the committee, a Mr Price, expressed the opinion that, '...if Mr. Figura was to be accused of lying then the evidence of consultant psychiatrists should be treated in the same way' (**The Times** 30.4.1982:3d).

The question of who should be appointed to the new Mental Health Act Commission came in for some discussion. The Secretary of State for the Social Services, Mr Fowler, refused to appoint Larry Gostin, the former legal officer of MIND, as a commissioner because Mr, Gostin was seen by Mr Fowler as both too innovatory and too much on the side of mental patients (**The Times** 5.7.1983:3e).

The review of the Mental Health Act 1959 (1975) was based on consultations with the different professional and voluntary bodies, in particular MIND. The main issues of the review which were emphasized in Parliament were: the clarification of admission procedures; procedures for consent to treatment; the roles of social workers, nurses and other professionals such as psychologists; medical and nursing staff's protection against litigation; the development of a truly multidisciplinary service; the establishment of the Mental Health Act Commission; guardianship and community care.

The Secretary of State for Social Services Mr. Norman Fowler said:

'The Bill is about the rights and interests of the public, the patients and the staff who care for those patients. The safety of the public is of obvious concern and we shall do everything possible to preserve that. Equally, it is important that we provide safeguards for those detained patients and the Bill does that by, for example, halving the time before a patient's detention in hospital has to be reviewed, giving increased access for patients to Mental Health Review Tribunals, and by setting up

the new Mental Health Act Commission...The Bill also gives nurses qualified in caring for the mentally disturbed power to hold an informal patient for up to six hours or until the doctor arrives if, in their judgement, it is clearly not in the patient's interest to leave hospital...The Bill provides for the replacement of mental welfare officers by Approved Social Workers, who will have to be specially designated and trained in the care of mental disorder' .(Hansard 1237:689-691).

The approaches here reflected the principles that detention should be imposed only where it was essential; there should be a proper right of appeal; and that detained patients were particularly vulnerable: their confused and/or disturbed state meant that it was important for their care and treatment to be subjected to safeguards. The House discussed the provisions in the Act for persons suspected by the police to be mentally disturbed. The relevant provision of the 1959 Act states that: 'If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care and control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons remove that person to a place of safety' (Mental Health Act 1959:91-92).

In the House, Mr Davis argued that the detention of persons for 72 hours by a police officer under Section 137 should be reduced to six hours, and that during this time the person should be interviewed by a psychiatrist and a social worker. He reminded the House that the British Medical Association had suggested a period of four hours. Mr Ennals replied that the Section should remain with the period of detention kept at 72 hours (Hansard 1254:91-93). Mr Mayhew reminded the House that the National Council for Civil Liberties had suggested a reduction from 72 to 24 hours.

The issue of the police removing persons from a public place to a place of safety (usually a mental hospital) raised the question, how can a police officer with little or no training in psychiatry detain someone for 72 hours? Surely if such a person was brought into a mental hospital by a police officer he/she should be interviewed immediately by a psychiatrist and a social worker. Being required to wait for up to 72 hours for such an interview appears to be a social control function effectively reducing a person's liberty.

Members of the House, in particular Mr Christopher Price, were concerned with the provision of adequate resources to local authorities to make these changes possible (Hansard 1237:691). Questions were also asked about whether patients would be able to receive legal aid so they could be properly represented at tribunals (Hansard 1237:696). Mr Fowler's view was that this issue of legal aid would be kept under review.

Members saw the new role for social workers as not only ensuring a more positive contribution to discussions about admissions, but also as providing information concerning the social circumstances of patients. Social workers were seen as key workers before and immediately after admission. As Mr David Ennals put it:

'A social worker may know a great deal about the background of someone admitted to hospital...The social worker may also have a professional view about how to deal with the patient's problems...There is a strong case for the involvement of the social worker...We need the maximum amount of knowledge to decide the necessary treatment for each patient. A social worker may know the family background, which may help the doctors to decide what is best for the patient...The wisdom of the social workers can be added to the professional experience of the doctor who must decide the treatment' .(Hansard 1254:44).

Many of the debates concerned nurses. Issues were raised by Mr Terry Davies about the possibility of sexual relations between nurses and patients; he reminded the House that the Royal College of Nurses had asked for the Act to end the discrimination between male and female nurses. He said:

'I agree with the Royal College of Nursing that it is indefensible in 1982 to discriminate between men and women in this way. I suspect that the reason for this apparent discrimination against men lies in an old-fashioned attitude to women. It is an offence for a male officer to have unlawful sexual intercourse with a female patient, but it is not an offence for a female officer to have unlawful sexual intercourse with a male patient because it is assumed that the man is dominant in such matters. In my view, the House should reject such attitudes and assumptions'.
(Hansard 1254:88-89).

This amendment was carried; where the 1959 Act stated 'for a man' in respect of this section, the new Act stated 'for a person'.

Mr Stan Thorn cited the situation at Wexham Park Hospital where a consultant psychiatrist prescribed a treatment that was unacceptable to the patient and to the nursing staff who had to administer it. He expressed the view that:

'Although on occasion the non-medical professions may, on the basis of their special expertise, judge that the doctor is mistaken and is proposing inappropriate treatment, they have no right in law to question his judgement or to intervene to protect the patient. It means that patients have no right in law to a multi-disciplinary approach to their treatment. If a doctor wished to ignore the views and skills of the non-medical professions, he

may not be following good practice, but he is perfectly entitled to do so. The ethical obligation of each professional who deals with a patient and the duty of care owed by each professional to the patient is subordinate to the doctor's judgement. There is no explicit obligation on a doctor to temper his decision... Evidence given at disaster inquiries shows that some doctors believe that they are entitled to be autocratic and to disregard other opinions' .(Hansard 1254:106-107).

Mr Pitt agreed with the position taken by Mr Thorn and asked for multi-disciplinary representation to be made stronger in the Bill. Mr Terry Davis also agreed with the position taken by Mr Thorn and Mr Pitt and asked for consultations to take place with nursing staff and other professionals during the decision making process (Hansard 1254:107-108).

The issue of multi-disciplinary consultations and discussion between doctors and other mental health workers such as nurses, occupational therapists and social workers was the theme of further debates when the House considered the new sections concerned with consent to treatment. While the House generally supported the doctor's leadership and power in relation to consent, members pointed out that there was nevertheless a need for doctors to consult with the wider team. As Mr Kenneth Clarke put it:

'Everyone in Committee agreed - and the opinion is shared by all those who are following the best modern practice in the care of the mentally ill outside-that it is good practice for the professional team caring for the patient to work together in close consultation and co-operation' .(Hansard 1254:110).

As a result of much of this debate the 1983 Mental Health Act in Sections 56-64 details the relationships expected between doctors and the wider mental

health care team when treatments with or without consent are being considered. The Act recognizes that although the doctor makes the final decision and he/she takes the final responsibility, nevertheless he/she should discuss the treatment options with other members of the clinical team. If, however, a second opinion is required then the independent doctor must consult a mental nurse and one other person, not a doctor or a mental nurse, usually a social worker, occupational therapist or a psychologist. Here we see a clear change in the Act in stating the situations when a mental nurse must be consulted.

The House debated the new six hour holding power of mental nurses. Mr Christopher Price expressed fears that with this holding power any patient who entered a mental hospital would be in danger of having their civil liberties invaded. He argued that the holding power could be used on any patient admitted compulsorily or informally, because if such a patient should try to leave when technically free to do so a mental nurse could institute the holding power (Hansard 1237:727-728).

The House questioned the protection against litigation given to doctors and mental nurses under the 1959 Act, Section 141. Mr Charles Irving said that:

'It is widely known that where a doctor unlawfully treats a patient against his will or a nurse assaults a patient, the patient can sometimes be prevented from going to court and receiving a fair hearing? This section 141 is perhaps one of the most unjust and discriminatory provisions in mental health law. It violates one of the most basic human rights - full and fair access to Her Majesty's courts of law'. (Hansard 1237:714).

Mr David Ennals entered the debate by stating clearly that 'Section 141 of the 1959 Act, requires that a patient shall not bring any proceedings relating to

any act done in pursuance of the Mental Health Act without leave of the High Court, which must be satisfied that there are substantial grounds for the contention that the person to be proceeded against has acted in bad faith or without reasonable care' (Hansard 1237:709).

Although debates and discussions took place around the issue of protection against litigation for staff, the 1983 Mental Health Act more or less retained this section. This means that there is still a system in which it is difficult for patients to get redress in the courts.

The new body, the Mental Health Act Commission, received both welcoming and dismissive arguments in the House. Of it Mr Fowler said that:

'We also have safeguard of the independent Mental Health Act Commission, which I regard as the single most important innovation in the Bill. The commission will, in a sense, carry on where Parliament leave off. When Parliament has finished debating the Bill, the Mental Health Act Commission will take over the role of watchdog for detained patients' (Hansard 1237:693).

Members who saw the positive side of the Mental Health Act Commission viewed it as a body which could focus its attention on the special needs and position of informal patients, and particularly compulsorily admitted patients. Some Members questioned the powers of the Mental Health Act Commission. Mr Michael Meecher said:

'I wish to ask the Secretary of State about the Mental Health Act Commission. Does he agree that there are two substantial weaknesses in the excellent proposal for the commission? First the commission will be able to deal with the 93 per cent of

patients who enter hospital informally. Secondly, while the commission is empowered to investigate the complaints of detained patients, it has no power to take any action if it finds that a person has been detained unlawfully'. (Hansard 1237:693-694).

Sir Derek Walker-Smith added to this:

'However, I should like to be assured that before deciding on the creation of the new, large and presumably expensive body my right Hon. friend has satisfied himself that the performance of these tasks cannot be undertaken within existing machinery. The commission will be what is sometimes called a quango. I am able in the Churchillian phrase in another context without difficulty to restrain my enthusiasm within the bounds of decorum. The onus of showing the necessity for any quango must clearly lie on the person seeking to set it up. I hope that my right Hon. friend will be able to show beyond peradventure that the onus is discharged in this instance' .(Hansard 1237:705).

The House agreed to institute the Mental Health Act Commission as a new group of overseers of mental health patient care and treatment.

There was general agreement that the Bill should address and improve the way treatments were carried out, particularly the conditions of consent to treatment and how consent to treatment was achieved. As Mr David Ennals said:

'It has been argued that questions of consent to treatment are too important to be delegated to doctors alone. I agree. The

Government have to some extent recognized that by their statement of intent to introduce amendments providing for a multi-disciplinary panel to confirm consent in cases of treatment giving rise to special concern. The Government having being pushed in that direction, I hope that in Committee we can push them a little further down the road' . (Hansard 1237:711).

Mr Charles Irving expressed his opinion that:

'There are many aspects of the consent provisions in the Bill that I applaud. The requirement for a patient's consent, plus a multi-disciplinary confirmation of that patient's consent to treatment that gives rise to special concern must be welcomed'. (Hansard 1254:83).

Critics of the 1959 Act such as Gostin (1975) had pointed out the need to change how consent was sought from patients for different treatments. The House appeared to be taking this issue seriously in their consideration of the liberty of the subject.

Mental health services and the political process

From the discussions in the House at the time of the passing of the 1930 Mental Treatment Bill, the conclusion can be drawn that Members were not really very interested in the plight of the mentally ill. Only a minority of members participated in these debates. Generally the politicians viewed mental illness as similar to physical illness. The feeling was that if the public agreed with this view, the stigma of mental illness would be eliminated, or at least minimized.

The reports in **The Times** show clearly that the Mental Health Acts were designed to produce changes in the way treatment, care and patients' rights

are dealt with in the mental health services. There was, however, no systematic discussion of any group of health care workers apart from doctors. Major concerns in the debates were the encouragement of early hospitalization and reducing the public's fear of mental hospitals; the voluntary admission of patients; the need for a more humanitarian approach to the mentally ill; and an attempt to endorse citizen's rights to ensure that these were respected. There was general agreement that the admission, treatment and control of the mentally ill should reside with doctors rather than with Justices of the Peace or magistrates. Concerns were expressed about overcrowding; the quality of food and clothing; the size of mental hospitals; the age groups of patients; and the treatment of physical disease in these hospitals.

The 1959 Mental Health Act was debated in the House by a larger group of participating Members than the debates on the 1930 Bill. Between 1930 and 1959 the welfare state and the National Health Service were established. The care of the mentally ill became an integral part of the National Health Service. MIND was established in 1946 and started to play a strong role in campaigning for policy and legislation changes. The House of Commons contained not only interested Members but two psychiatrists and three doctors. A number of Members were also on hospital boards. The then president and vice-president and a future president of MIND were also Members of the House at that time, and this fact helped to keep mental health on the political agenda. All these factors probably helped to account for the increased participation of MPs in debates about the 1959 Bill.

The members of the House of Commons generally praised the existing system when debating the 1930 Mental Treatment Bill. They referred to voluntary admissions, which they saw as enabling patients to go in and out of mental hospitals of their own volition rather than through coercion. They did not consider that people might still be being persuaded to go into mental

hospital by relatives and professionals, or that they might stay in such institutions because there were no alternatives, or, that if they were in the community, they might be subjected to ridicule and hostility. Members approved of the treatments for general paralysis, the use of ECT and the new psychotropic drugs. They praised the establishment of day hospitals and observation wards in general hospitals, and the work of doctors, nurses, occupational therapists, social workers and psychologists.

The 1959 Act provided for the establishment of the Mental Health Review Tribunal at the same time as the dissolution of the Board of Control. Members saw the Tribunal as a step in the right direction towards achieving more rights for patients. The Tribunal replaced the Board of Control as the machinery which would ensure the continuation of an appeals process for patients.

Each Regional Health Authority had its own Mental Health Review Tribunal. The members of the Tribunals were appointed by the Lord Chancellor and consisted of a psychiatrist, a lawyer and a representative of the public. Tribunals had the power to discharge any applicant if they were satisfied that the applicant was not suffering from mental illness, psychopathic disorder, subnormality or severe subnormality, and was not a danger to himself/herself or to the public.

Many of the issues concerning caretakers that were raised in these debates centred on staff shortages and the need for recruitment programmes. Members expressed sympathy for the plight of caretakers and were critical of the Ministry of Health for not attending more to caretakers' needs. Caretakers were recognized as carrying the main burden of the mental hospital services and members questioned why this fact had not been translated into improved levels of training and pay.

Members supported the clinical-somatic approach to the treatment of mental

illness. This served to increase the control exercised by psychiatrists. Because of this, and through the new category of 'psychopathy', it could be argued that the definition of mental illness was increasingly used to solve difficulties in social control and the social definition of deviant behaviour, while tightening organizational and professional control.

The 1959 Act was seen by the Members of the House as a forward-looking Act. However, there were changes in mental health services and practices which made it necessary for a review which could lead to changes to suit the new approaches. An interdepartmental committee made up of the Department of Health and Social Security, the Home Office and the Lord Chancellor's Department was set up to consider possible changes. This committee received representations from the Royal College of Psychiatrists, Health Service Unions, the Royal College of Nursing, MIND, and from individuals. The terms of reference of were to review the 1959 Act and to make suggestions for change. Central to the review was the issue of under what circumstances society should have the right to deprive a mentally disordered person of his/her liberty and impose treatment considered to be in the interests of both the individual and the general public (DHSS 1975).

The 1983 Act was further influenced by the Report of the Committee on Mentally Abnormal Offenders (The Butler Report 1957). Pressure group activities included the MIND initiative in getting the House of Commons Standing Committee to question a patient about conditions in the mental hospital where he was a patient (**The Times** 30.4.1982). Another important initiative was the MIND Report: **A Human Condition: The Mental Health Act and Proposals for Reform** (Gostin 1975). This report was made available to the Department of Health and Social Security special working party set up to reform the 1959 Mental Health Act. Other parties interested in the reform of the 1959 Mental Health Act included the all party Parliamentary mental health group, mental health workers, self-help groups, community action groups

and the National Council for Civil Liberties. The role of these pressure groups was to ask for a fair deal for mental patients through legislation in order to secure a protective framework of rights.

They felt that a refurbished Mental Health Act could open up new therapeutic possibilities, offer some insurance against neglect, reduce the exaggerated reliance on professional judgements and provide some hope for the people who have traditionally been put away out of sight and out of mind.

The 1983 Act changed the compulsory admission procedure of the 1959 Act. The power and responsibility was retained by doctors with new responsibilities given to social workers and hospital managers. Relatives retained certain rights to discharge the patient, and new opportunities were opened for appeals to a Mental Health Review Tribunal.

Compulsory detention and the role of the psychiatrist

Although it was agreed by Members of the House and the professionals that patients should always be admitted informally, there was also support for the retention of compulsory admission (Hansard 1237:689-691). Compulsory admission was recognized as involving deprivation of liberty, restriction of individual rights and freedom of action. The 1983 Act, therefore, was designed to ensure that the mental state which justifies compulsion was clear, and that alternative forms of treatment had been considered. Bluglass (1983) has argued that the search for a more clearly specified compulsory admission procedure actually resulted in more restrictive practices, with an emphasis on treatability.

The legislation for compulsory admission required that less severe forms of mental disorder did not warrant detention, whilst other conditions considered to be severe could justifiably result in compulsory admissions. The 1983 Act contains phrases such as that the patient's psychiatric condition must be 'of a

nature or degree' that harm to self and or others were sufficient to warrant compulsory admission. Compulsory admissions required two medical recommendations, one by a psychiatrist, and the other by a registered medical practitioner, preferably a GP. This admission procedure had to be followed for the 28 day order for assessment and for the 6 months order for treatment. The need for two recommendations was rooted in the history of psychiatry. There have always been fears that a doctor might railroad an unsuspecting patient into a private asylum. Therefore, all legislation since the nineteenth century retained the practice of two doctors being involved, one to act as corrective to the other. However, as Bean (1986) has pointed out, since one doctor is the consultant psychiatrist and the other a GP without specialist psychiatric knowledge, the status relationship between the two is likely to result in decisions about the admission procedure being dominated by the opinion of the psychiatrist.

The question here was at what point a certain degree of severity was considered to be less severe or more severe. Questions of interpretation and moral issues are involved. The psychiatrist must show that compulsory detention is justified. Part of this justification could be that severe mental disorder imposes greater physical, psychological and social suffering on the patient and intense stress on relatives, friends and the community. It proved difficult to clarify the legal and moral issues. But the practice of assessing severity, and the moral basis of any judgements made were of considerable importance to questions of individual rights. The shortcoming of the Act was that it did not state the severity, or the types of behaviour which would warrant compulsory admission.

To justify the need to admit someone compulsorily some psychiatrists, according to Bean (1986), argued that if individuals were left untreated they were likely to harm themselves or others. Yet when such individuals were admitted compulsorily, they could exercise a right of appeal.

The role of social workers

The changes in, and clarification of the doctor's role vis-a-vis compulsory admissions occurred in parallel with the changing roles and new responsibilities of social workers. Social workers working in mental health and having a responsibility for making applications to a mental hospital for the admission of a patient must now belong to the category of 'Approved Social Worker', which means that social workers have to undergo special training. MPs agreed with the changes to the social worker's role and function (Hansard 1254:44). The 1983 Act required the Approved Social Worker to interview the patient, to advise the psychiatrist of alternatives to hospitalization and to prepare a report for the hospital managers. As in the 1959 Act, the social workers also retained their central role of making applications for admission in the absence or reluctance of the nearest relative. With these greater expectations, and increased powers and responsibility, has come a demand for greater competency. The question is also raised about social workers' roles in relation to the protection of patients' rights. If a social worker rejected medical opinion for an admission and refused to make an application for admission, the doctor could ask the nearest relative to make the application instead. If the social worker opposed the admission and the patient harmed himself/herself, the social worker could be said to be failing in his/her duties. Overall, the new duties of the social worker asks for the patient's social situation to be considered and his/her rights to be respected.

The role of caretakers

The 1983 Act instituted a new role and function for caretakers. It introduced the right of caretakers to be able to invoke a holding power for up to six hours. The decision to introduce this new power was debated in the House and the amendment was passed (Hansard 1237:727-728). In the Parliamentary debates few Members appeared to be apprehensive about

this. According to Bean (1986), members were more concerned with the need to hold, rather than the power in the holding. Section 5 (4) of the 1983 Mental Health Act stated that the purpose of the nurses' holding power was to allow the detention of a patient already receiving treatment for mental disorder in hospital until a doctor was found. The mental nurse could invoke this section if it appeared that the patient was suffering from a mental disorder and that it was necessary for his/her health and safety, and for the protection of others that he/she be restrained from leaving hospital. The mental nurse must record this decision in a report and deliver it to the managers of the hospital as soon as possible.

This new holding power cleared up the legal position of the caretaker when restraining informal patients or patients whose compulsory detention period had ended. It can be argued that the holding power was not necessary, as there were always doctors available to detain such patients, and in any case common law allowed for a mentally disordered individual to be restrained for his/her own health and safety. There were hospitals where doctors were readily available, for example London teaching hospitals, but there were also institutions where doctors were less numerous, for example hospitals in the countryside of Surrey or Kent. There might also be problems about the availability of doctors at night. It must be remembered that even during the daytime it was the caretakers who were present during the twenty-four hours; doctors had to be called. There were other issues about the role of caretakers. These included criticisms of caretakers functioning in locked wards, having to deal with violent patients and the concerns of social workers and MIND that caretakers might sometimes be keeping patients in and infringing their rights. As a consequence of these pressures, caretakers pressured their unions, in particular COHSE (Confederation of Health Service Employees) to represent them in seeking clarification of their role and legal position (Martin 1984). By demanding such clarification, it could be argued that caretakers were seeking more influence in hospital in relation to which patients should and should not be admitted.

Protection against litigation for mental health workers

Members of the House debated extensively the provisions in the 1959 and the 1983 Mental Health Acts giving protection against litigation to doctors and mental nurses (Hansard 1237:714, and Hansard 1237:709). The section in the 1983 Act which dictated this provision is section 139. This states that no civil or criminal proceedings can be brought against any person in any court in respect of an act done under the 1983 Act without leave of the High Court or the Director of Public Prosecutions, and that for such proceedings to proceed, the court must be satisfied that the person proceeded against acted in bad faith or without reasonable care. This section, argued MIND (Gostin 1975), makes it difficult for patients to have a fair public hearing by an independent and impartial court. Others, such as Bean (1986), have suggested that the State's interest was in wanting the Mental Health Act to be operational, so that the co-operation of doctors and others was required, and they in turn argued that to do the job properly they needed protection to avoid prosecution and the possibility of being sued for honest mistakes.

Consent to treatment rules

The 1890 Lunacy Act gave medical superintendents power to administer treatments to certified patients without the patient's consent. These powers were transferred to the 1930 and 1959 Acts. The 1983 Act changed the powers doctors had in executing treatments. This was the first time that statutory legislation covered consent to treatment for all patients whether admitted informally or formally. To arrive at this new inclusion in Mental Health law there were long debates in Parliament (Hansard 1237:7-11 and Hansard 1254:83). The basic principle concerning consent to treatment was that the patient's informed consent is required before certain treatments can be administered. If the patient refuses to give consent, treatment may be given only if an independent psychiatrist agrees and after he/she has consulted a nurse and one professional in the team who knows the patient. The other professional can be an occupational therapist or a social worker. The

independent second medical opinion must be given by a doctor appointed by the Mental Health Act Commission. Medication may be given without the patient's consent and without the need of a second opinion for up to 3 months. After this period, consent or an independent second opinion is required. The treatments which required consent and a second opinion were ECT, surgical implants and any surgical operation for destroying brain tissue.

The issue of consent to treatment was a way of reducing the control which was a major feature of mental hospital life. This control was stressed by the doctors, nurses, allied paramedical professionals and administrative staff. By seeking consent from patients, the 1983 Act offered an exercise in choice and a respect for patients' rights which was never available before. However, the other forms of control remained untouched. The patient could not have choice over the hospital organization and system, nor could he/she leave the hospital. Consent was a valuable freedom, but it co-existed with the loss of other freedoms.

Concern in the House about consent for treatment led to debates and questions which examined the multi-disciplinary functioning of professionals (Hansard 1254:106-107 Hansard 1254:107-108 Hansard 1254:110). The 1983 Act recognized that the Responsible Medical Officer had to make the final decision concerning admission, treatment and discharge of the patient. But the Responsible Medical Officer was required to develop a good working relationship with the other members of the team and to consult them in any decision making concerning patients. With the abolition of the Board of Control following the 1959 Act, the Royal College of Psychiatrists was concerned that no independent body was to replace the wide and authoritative function of the Board. The College, according to Bluglass (1981), continued to recommend the case for a permanent, independent commission, to protect the interests of the individual patient and to promote high standards of care. The 1983 Act established the Mental Health Act

Commission, to provide independent medical opinions for consent to treatment and second opinions, to visit and interview patients when complaints were being investigated, and to develop a code of good practice.

The Commission was a special health authority with a critical policy committee in London and three regional panels based in Nottingham, London and Liverpool. The Commission consisted of a Chairman appointed by the Secretary of State, 12 lawyers, 12 nurses, 12 psychologists, 12 Social Workers, 12 laypeople and 22 psychiatrists. It was required to present a report every two years to both Houses of Parliament.

The functions of the Mental Health Act Commission included paying attention to patients' rights. However, there are limitations in some important respects. It has no powers to deal with informal patients, who make up 90% of the hospital population. It cannot compel the attendance of witnesses or receive information on oath. It cannot provide patients with the right to see their medical records. It does not have the power to enforce any codes of practice developed, which therefore remain at the level of a set of proposals.

It is important to note that the Commissioners appointed by the Secretary of State were unlikely to be campaigners of patients' rights. The appointed individuals were prominent and well-connected people anxious to avoid wounding the sensibilities of conservative medical and nursing professions (Rassaby and Rassaby 1983).

Mental health legislation throughout the period 1890 - 1990 reflected the views of psychiatrists and members of the Houses of Parliament. The psychiatrists saw the legislation as helping them to have control over the people they regarded as requiring diagnosis and forms of medical intervention. MPs saw themselves as providing a legal framework which would ensure that the people deemed to be insane were satisfactorily

contained and treated. This legislation also provided for changes in the compulsory detention of the insane, the treatments offered, in the roles and involvements of social workers, in the rights of patients and in caretakers' roles and functions. However, the basic medical domination and social control aspects of mental health care remained intact.

CHAPTER 9

CHANGES IN CARETAKERS' ROLES

The caretakers who form the focus of this study were the attendants and nurses who provided care within hospitals for the insane. Before 1890 these caretakers were the majority of the work force in the insane asylum. They did not have a systematic approach to their work, and they lacked training; the care they offered emphasized institutionalization, and their work consisted mainly of keeping order by controlling the inmates, and keeping the institution clean and the inmates busy. With the emergence of the asylum system, caretakers came to be called attendants; they were the medical superintendent's servants and their primary duty was to carry out his orders. Later female attendants were referred to as nurses, while men continued to be called attendants.

This chapter looks more closely at the roles and responsibilities of caretakers over the whole period under study, and at what aspects of their work really changed. The nature of the work of caretakers in asylums and mental hospitals during the period under study shows clearly that their roles were crucial in determining the quality of the treatment and care given to patients. The relationship between caretaker and user was, and still is, an unequal one with the caretaker in a position to exercise considerable power.

As the two previous chapters have shown, Government policy, as reflected in the mental health legislation of 1890, 1930, 1959 and 1983, included a concern with patients' rights. The 1890 Lunacy Act attempted to safeguard the liberty of the citizen by instituting procedures for admission, and developing the asylum system as a way of encouraging greater legal protection for the insane. The 1930 Mental Treatment Bill sought to reduce legal formalities in the interest of early treatment. Voluntary admission was sought for the majority of patients, with certification only being used when

deemed to be necessary. The 1959 Mental Health Act was conceived as an integral part of the development of the Welfare State and the National Health Service. It was an attempt to provide a legal framework for the achievement of national psychological wellbeing (Unsworth 1987). This Act saw the introduction of the Mental Health Review Tribunal to which patients could appeal. It effectively shifted procedures from the legal to a more medically dominated approach, with much of the responsibility for the running of the system left to doctors. The 1983 Act restored formal legal safeguards by imposing stricter criteria for admissions and a more judicial approach to the procedures of commitment. It strengthened patients' rights to resist unwanted treatments and restrictions on their civil freedoms. While the Act retained the Mental Health Review Tribunal, its procedures were sharpened; a new body, the Mental Health Act Commission, was developed to monitor patients' rights.

The asylum system

The asylum system was brought about by the 1890 Lunacy Act. Under the system which pre-dated this, most of the caretakers of the insane were agricultural workers employed for their strength, army men who could provide discipline and rule keeping, and women who otherwise would work as domestic servants. With the introduction of the asylum system, medical superintendents looked for different qualities in recruits, such as the ability to relate to patients, to be skilled in an occupation and to have had experience of the insane, for example people whose parents had worked as attendants and so had been brought up in the asylum environment. The ideal recruits were men and women of high moral character, a good education, strict temperance, kind and respectful manners, cheerfulness and compassion. Those superintendents who had been influenced by the Quaker-inspired Moral Management Movement saw the attendant as a spiritual guide who showed Christian principles in his/her work.

The majority of asylums were similar to small manufacturing towns where

self-sufficiency and keeping the patients occupied were the main duties of the staff. The system was run according to the idiosyncrasies of the medical superintendent; he laid down what the caretakers did. The attendants' role and functions including following the rules and regulations laid down in the rule book which were to be enforced on patients, helping to run the asylum farm, administering treatments such as cold showers and the 'bath of surprise' (getting the patient in a bath without prior warning), occupying patients with shoe-making, building, gardening, music, sewing, cooking and dancing.

The asylum system reflected the increase in the power of the state over the lives of individuals. Although the rhetoric of the asylums was that they were medical institutions, the work of the caretakers involved restraining, seclusion and solitary confinement. To enable the caretakers to carry out these control functions, muffs, straight-waistcoats, leg locks and coercion were used. But the main bulk of the caretakers' work continued to be similar to the work of domestic servants: cleaning, polishing, bed making, dressing and serving meals to patients; attending to bedridden and paralysed patients. Caretakers managed the abused, boisterous, aggressive and violent patients. They administered cold dressings, poultices, fermentations, enemas and suppositories, packing patients in wet sheets to reduce mania. They controlled and administered tobacco, beer/alcohol, tea, snuff, sugar, opium and hyoscine (Hunter and Macalpine 1974).

Working closely with the state in establishing the asylum system was the medical profession, keen to exploit this emerging branch of medicine for its members. The doctors were aiming to cure and, through the use of the disease model, claimed scientific respectability. According to Mitchell (1984), this perceived power to cure gave doctors a legitimizing ideology which underpinned their power and prestige in the asylums. Jones (1991) argued that the asylums reflected Victorian society in miniature, because they were

undemocratic, paternalistic and class-conscious. The vast majority of patients came from the destitute poor and many superintendents saw the asylum primarily as a mean of distributing welfare. Others took the view that the institutions were character-reforming organizations with the principal agents of reform being the caretakers.

During this period, voluntary agencies began to play a part in the provision of care. The earliest of these was the Mental Aftercare Association, which was founded in 1879 (Rooff 1973). The Association's work was mainly concerned with residential aftercare, which took the form of placing ex-patients for short periods in convalescent homes run by ex-matrons or senior nurses from the asylum.

The Mental Aftercare Association along with the training initiatives of the middle nineteenth century contributed to the early development of community care. Yellowlees (1955) observed that there were local training courses for attendants which stated that trainees should have contact with the families of patients, and that they should also go with patients to see their relatives, and find out how the disease arose.

The 1930 Mental Treatment Act and the increase in voluntary admissions resulted in a great deal of admissions and discharges. Doors were unlocked, restrictions on patients' freedoms were lifted and some of the depersonalizing practices were combatted. It was against this mixed background that the first formal development took place in extending the mental nurse's role into working outside the hospital itself, either in caring for discharged patients, or to work with out-patients. The mental nurses who wanted to develop the community care approach emphasized the development of the therapeutic community/milieu therapy model and placed much less emphasis on physical treatments and the need for discipline, control, routine and cleanliness. The Community Psychiatric nursing service at Warlingham Park Hospital in 1954

was characterised by the nurses working from an office in a mental health centre attached to a day hospital. Their working day consisting of visits to patients' homes and work places, day and afternoon out-patients clinics, running after care groups for long stay patients and organising evening social clubs. They also shared in regular case conferences to review the patients' progress and their working activities (Hunter 1974).

Training and treatment

The changes in state provision for the insane following the 1890 Lunacy Act resulted in changes in caretakers' work and function. Training was established which covered: the body, and its general functions and disorders; the care of the insane and the general duties of attendants; obedience and discipline, personal neatness and courtesy to patients; the avoidance of ridiculing delusion; the importance of comfort for all in the asylum; care and observation of epileptic and suicidal patients; restraint, seclusion and artificial feeding; bandaging and treatment of wounds, sores, bruises and burns; bathing patients; and the importance of occupation, amusements and religious services. Sport was a dominant part of the life of mental hospitals; patients, staff and relatives all participated (Jones 1991).

The training was provided by the medical staff and on occasion by the Head Attendant; the Medico-Psychological Association organized the examinations and provided the certificates for successful candidates. The book which provided for the training was: **The Handbook for the Instruction of Attendants on the Insane** (Clark *et al.* 1884).

The handbook represented a shift from the oral tradition to a written one. Without doubt it was a significant move in the history of the education and training of mental nurses. Nolan (1993) argues that, although the handbook contained medical rather than mental nursing knowledge, it gave the work of mental nurses credibility, and facilitated some degree of unification of mental

nursing practice throughout the country.

The 1930 Medical Treatment Bill was passed in a climate which stressed the need for early treatment and for treating mental disease in much the same way as physical disease (Hansard 235:958). There were developments which resulted in the successful treatment of conditions such as general paralysis by physical somatic means. Many patients were being treated with insulin therapy, ECT, psychosurgery and chemotherapy. What this amounted to was that the state, doctors, the public and caretakers were all stressing the physical causes of mental illness, and the need to take certain necessary steps to provide a cure. The new treatments were being carried out by caretakers who were both unsure about what they were doing and ill-informed about possible benefits and hazards (Clark 1964). Caretakers were faced with the dilemma of claiming to be engaged in treating curable mental illness while they knew very well that most of their patients would not be cured, and might never leave the hospital. In reality what patients received was custody, not therapy. Caretakers used straight jackets, padded cells and forced feeding whilst trying to project an image of carers and healers. Also at this time a form of community care was expected, but local authorities did not have the resources to meet the increasing community care demands.

The training changed during the 1930s with Medical Superintendents encouraging the study of psychological explanations of mental illness. A new textbook, **Fisher's Modern Methods of Treatment: A Guide for Nurses** was published in 1948. The book saw nurses as doctors' assistants, who would implement the doctor's treatment regimes, keep patients under observation and report their observations to the doctors. It also mentioned the power which nurses have in influencing the wellbeing of patients.

This period saw the emergence of a more therapeutic caretaker. Caretakers were learning and developing the skills of psychotherapy and social therapy.

The Cassell Hospital, which opened in 1919, provided the on-going education of its staff. Here caretakers played a full role as therapists and multi-disciplinary team members.

The 1959 Mental Health Act brought changes in the need to expand and develop community care. Caretakers were by this time working in the community. This initiative began at Warlingham Park Hospital in Surrey. At the same time, there was an expanded role for social workers, psychologists and occupational therapists within the mental health services. With these developments and the increase in the use of psychotropic drugs, new questions were emerging as to the role and function of caretakers. Hunter (1956) has suggested that the introduction of psychotropic drugs resulted in the deskilling of caretakers, while caretakers themselves felt that their therapeutic role had been reduced to the giving out of medicines. Studies were undertaken to examine the work, role and function of the mental nurse. For example, in 1954 the Liverpool Regional Hospital Board looked at the nature and status of mental nursing, and the Manchester Hospital Board undertook a similar study in 1956. In 1966 Oppenheim and Ereman examined the role and training of mental nurses; this was followed by the work of Maddox (1957) and John (1961). All these studies reported the complex activities involved in mental health work, the shortages of resources for caretakers' work, and the difficulties that were being experienced in recruiting suitable candidates. Further, they suggested that some aspects of the work of mental nurses had only the slenderest claim to be related to patient care.

The Liverpool study (1954; Macguire 1969; Nolan 1993) found that the hospital operated with chronic staff shortages, that students were withdrawing from the training, and that staff adhered to the view that skills could not be taught, but could only be acquired through practical experience. Most of the students were recruited as nursing assistants and then persuaded to train. There was no minimum educational qualification required. The study

concluded that better selection and an improved training programme both in the classroom and in the wards would help to alleviate the chronic shortage of staff.

By 1960 the emphasis had shifted from looking at the role of the mental nurse to examining the personalities and attitudes of those engaged in the occupation. Menzies (1960) argued that nurses worked within a social system which protected them from anxiety. This social system created a detachment of the nurse for the patient through rituals and the routinization of self-care tasks.

The development of community psychiatric nursing was followed by the training of these new workers. The first course was offered by Chiswick College in the early 1970s. These community psychiatric nurses gained recognition through the skills which their community training offered them. The training saw caretakers enhancing their skills in interpersonal relations, group skills, psychotherapy, behaviour therapy, counselling and research.

The 1983 Mental Health Act provided for a continuation of the development of the caretakers' work in the hospital and in the community. Specialist courses were now widespread, and ranged from diploma to graduate and post-graduate qualifications. There were well-established community teams which worked in close association with GPs, health visitors and social workers. But the 1983 Act changed significantly the role of the caretaker in hospitals, as it allowed caretakers to detain an individual for up to six hours.

Public views and caretakers' work

The context within which caretakers worked was determined to a large extent by the views held by society about insanity. Social attitudes towards people with mental disorders have always influenced the quality of care which they receive. The inheritance theory held that insanity could be transmitted from

generation to generation. The moral degeneracy theory considered that the poor possessed badness of character. White (1888) divided the poor into three categories: the genuinely unemployed, the feckless and incapable, and the wholly degenerate. He felt that there was nothing to do but let them die out by leaving them alone. Such views about insanity meant that containment and separation was the dominant approach taken to caring for the insane. The eugenics movement recommended that measures should be taken to detect and isolate people likely to become insane, and that they should be segregated and prevented from reproducing. With these theories in mind, asylum patients were seen as degenerate, and caretakers had instructions to guard against associations between males and females. The miasmatic theory, which assumed that dirt and putrefaction are the main cause of ill health, led asylum superintendents to be preoccupied with hygiene. Caretakers were required to concentrate on cleanliness; walls were whitewashed and floors were scrubbed several times a day. Caretakers were required to supervise bathing and to ensure that patients' bodies were clean and free from lice. The contagion or germ theory, which assumed that the vectors for disease were humans, resulted in categorization and segregation according to condition so as to prevent cross-infection. Patients were subjected to long periods of airing in individualized 'airing courts'. The other popular theories were vitamin C deficiency and the septic foci theory of insanity. In instances of septic foci insanity doctors would remove what they thought was the source of the infection and hence the insanity. Patients' teeth, tonsils and parts of their alimentary canals were removed in adherence to this theory (Hunter and Macalpine 1974).

Much of the work of the caretakers of the insane was carried out within a covenant relationship and within a web of connections (Gilligan 1982). The covenant relationship is clearly seen in the rules, regulations and procedures which govern caretakers' work in the institutions. If these rules are followed rigidly they are likely to result in inclusions and exclusions. The covenant

relationship therefore has limitations because it implies an agreement entered into by both parties, but both parties - the patient and the caretaker - are not equal, and the patient's involvement seems to be merely to trust the nurse (Cooper 1989).

Given the amount of social control which takes place in services for the insane, patients often neither trust the nurse nor work co-operatively to foster their own well-being. On the other hand, caretakers, it can be argued, offer a web of connections, a dialogue relationship which emphasises the patient's well-being through fostering hope, listening, enabling self-awareness and growth and teaching patients how to self-care. As Gilligan (1982) suggests, effective caretaking is more of a possibility in a dialogue relationship.

The caretakers' role and work changed not only with conceptions of insanity but also according to medical superintendents' views of its causes. A problem for caretakers then which remains today is whether their role is primarily that of a domestic labourer or of a carer. A further enduring conflict is that between being an agent of treatment and an agent of control. Caretakers have always been involved in maintaining a system that promotes order and regularity for its and their own sake rather than for therapeutic objectives. Caretakers have been the arbiters of a conflict between the demands of institutional efficiency and the declared intention to maintain humane standards.

CHAPTER 10
CONTEMPORARY CARETAKERS: THEIR REFLECTIONS
ON THEIR WORK

This chapter explores the reflections of nine contemporary caretakers including those of the researcher on the nature and implications of their work. The contemporary caretakers asked to contribute to the investigation expressed their willingness to participate because they saw the new legalism within the mental health legislation brought in by the 1983 Mental Health Act as affecting their ability to give the care and treatment which they saw as necessary. The main focus of their reflections was on the dilemma for caretakers highlighted in previous chapters between caring, treatment and the respecting of the rights of users on the one hand, and being agents of social control on the other.

Evidence from contemporary caretakers through interviewing was an integral part of the investigation; its purpose was to provide information from caretakers who were exposed to the changes brought about by the 1959 and 1983 Mental Health Acts. These caretakers were being asked to reflect on how they saw their social control functions and how they felt users' rights were being catered for at the historical moments of 1959 and 1983 which are within the historical period being looked at, 1890 to 1990. By selecting caretakers who have experienced the introduction, the workings and the critiques of the two mental health legislations, it was thought that their comments would illuminate further the issues around care, treatment and rights within the mental health services in which they worked. Considering that the historical documents and sources used were all written for audiences at those particular times. The interviewing of the contemporary caretakers, it was hoped, would yield information which related directly to the work at hand through oral history. Such an oral history fits well with Mann's (1985) argument that it is not necessary always to think of the interview as only the

highly standardized sample type. It may be that a particular investigation needs to focus on selected people for information. The people interviewed would be key participants with useful knowledge whose interviews would yield worthwhile information. Mann also suggested that if a historical perspective was being looked at, it may well be quite invaluable to interview people for their memories of how it was many years ago. In recent years the development of oral history has resulted in many interviews with older people being tape-recorded for the development of sound archives. An example of this work is the taped interviews carried out for the Imperial War Museum in London of survivors of the 1914 to 1918 war (Mann 1985). It is that memory of how the contemporary caretakers worked with users and addressed the social control and the rights issues that the interviews were designed to capture.

The contemporary caretakers were approached by telephone with a brief description of the proposed investigation. This was followed by a letter which introduced the investigation further, see Appendix (3). They were telephoned again to ask for their verbal agreement that they would participate in the investigation, and to arrange the dates and times for the interviews. The interviews lasted for half an hour and they were tape-recorded, see Appendix (2) for the interview schedule. The tape-recording was then transcribed and a copy sent to the respective interviewee, who was asked to check to see if the transcript was a true reflection of what had been said. The information collected from the caretakers was then checked to collect the caretakers' views on the following questions: Does mental health legislation facilitate the care and treatment of the insane? Does mental health legislation provide for the social control of the insane? Does mental health legislation result in changes in the work of the caretakers? Are patients' rights a part of mental health legislation?

Contemporary caretakers in current nursing journals are referred to as 'psychiatric nurses', although there is no such statutory qualification. The statutory training confers the qualification of Registered Mental Nurse (RMN), and the 1982 syllabus is labelled the Syllabus of Training for Mental Nurses. The new Project 2000 course introduced in the late 1980s uses the title 'mental health nurse'. These shifts in title, with workers variously accepting and denying their allegiance to the medical model, is an important part of the history of both the caretaking profession and the cultural treatment of insanity and mental illness, but they also serve to confuse and obscure the role and functions of the caretakers.

All the interviewees were chosen because I knew of their work. They included representatives from the areas of clinical practice, management, and education. They were all trained and registered mental nurses, and were working in senior jobs in the mental health services, in hospital, in the community and as teachers of mental nurses. To be eligible for these jobs they had all had three years' training, had worked for at least two years as a staff nurse, and for at least two years as a charge nurse or sister. They had experienced being a nurse with responsibilities for delivering care through negotiating with doctors and management, and in the teaching of students entering training.

Table 3 shows the age range and the sex of the caretakers interviewed. From the age range it is clear that these caretakers would have been working as Registered Mental Nurses at the time when the 1959 Mental Health Act was in operation, they would have had experience of the care situation when the changes of the 1959 Act were being debated, and also of the introduction of the 1983 Act. Six women were interviewed and three men, reflecting the fact that more women than men deliver care within the mental health services.

TABLE 3
DETAILS OF AGE RANGE AND SEX OF CONTEMPORARY CARETAKERS

Age	Male	Female
30-39	1	2
40-49	2	2
50-59		2
Total	3	6

Based on a total of N=9 interviewees

Respondent A: A manager of in-service education within a mental hospital.

This respondent saw mental health legislation as protecting the individual against abuse while allowing appropriate treatment to take place against his or her will, as giving guidelines and support to professionals, as allowing the reviewing of patients to occur more systematically and as affording patients more access to appeals. While mental health legislation goes some way towards protecting the individual from abuse, it does not simply allow staff to treat patients against their will. The Mental Health Acts, particularly those of 1959 and 1983, asked for certain conditions to be met. The 1959 Act required that the individual must be detained under the treatment Section (26), and the 1983 Act required that the consent to treatment rules Sections (57, 58, 59, 60, 61, 62 and 63) must be enforced. By laying down rules and procedures for admission and treatment, mental health legislation does give some degree of guidance to staff. The support to staff, however, must be examined in terms of the extensive protection from prosecution given to staff in the 1983 Act in carrying out their role and functions. This is stated clearly in Section (139) and reflects the difficulties patients have to overcome in order to bring a case against staff.

The 1959 Act and the 1983 Act allowed for the review of patients and access to appeals. Although the 1983 Act improved these areas, there were still time limits which has to be adhered to as to when a review should take place and when a patient may appeal. Mental health legislation, in particular the 1983 Act, has led to 'a straightjacket in one sense, in as much as we are more rule-orientated rather than having also to rely on what was in a sense good practice...I think one sees this in terms of the nurses holding power'. The appeals here to the staff's good sense and good practice is the old story of staff feeling that they are doing a good job and being taken for granted. There were centres of excellence, but given the lack of resources and poor training within which some caretakers worked and the catalogue of bad practices through the centuries it would be unwise to leave patients totally at the mercy of staff. The 1983 Act does ask for more procedures and rules to be followed; this is a good thing, as it leaves less to staff prejudices and idiosyncrasies. By formalizing nurses' holding power, staff do not have to keep pre-signed section (30) forms 'not here but heard of, where old Section (30) forms would be kept in the top drawer so that when a patient wanted to leave the signed form would be brought out and used'. The rights of the patients were made little of; the comment 'people now die with their rights on' and 'professionals may be more hesitant to intervene and give necessary treatment, because of the restrictions of the legislation', shows this. The assumption could be made that staff would rather move in to give what they consider to be necessary treatment without following the rules and procedures around consent to treatment.

The respondent felt that caretakers should have uncensored power to do as they please with the individual. He had a sense of sympathy with the rights patients may lose because of institutional practices such as the restriction placed on the individual by the institution, and issues relating to sexism, racism and privacy, which are taken-for-granted aspects of institutional life. He saw the 1983 Act as effecting changes in the role of caretakers. They were

required to see through the already mentioned holding power, to be more involved in care and treatment decisions, and to ensure that people were informed of their status in hospitals, their rights and the appeals system available to them. He highlighted how control could be used according to the resources available and the anxieties and fears of the staff. There were difficult situations, such as the care of the elderly, where without community resources they had to stay in hospital. As regards the care of young West Indian men, there was an associated fear of the person being aggressive and violent, and so staff would respond with social control through drugs. There was recognition that such uses of drugs may be unnecessary. 'So one must agree that with hindsight one might not have given medication.'

There was also recognition of the difficult work which the caretakers did and the lack of support available to them. The concept of 'caretaker' was appreciated because the concept took on board the possibility of holistic care. Emphasis was given to the tension between individual freedom and treatment in mental health care. 'I think there is a tension between giving the individual as much freedom as possible whilst at the same time making sure that he/she have access to appropriate care as soon as possible.'

Respondent B: A manager of a hospital and a community mental health nursing service.

This respondent saw mental health legislation as protection and control for the patient and the caretaker. She viewed such legislation as associated with the removal of patients' rights and with the protection of their rights through the appeals system. Staff were seen as being responsible for patients who cannot make their own decisions, and people who were out of control and needed controlling. The respondent thought that, by being professional and caring, staff can ensure that patients rights are respected. She did not feel that there was much difference between the 1959 and 1983 Acts. However, she stated: 'I think the 1959 veered on the side of control rather than on the

protection of rights. The protections were still there but the refinement of the 1983 Act was to add even more protection to what the patient had.'

There was a strong sense in which this respondent saw staff as control agents, with this controlling function as legitimate because staff would be acting professionally. Perhaps this use of the concept 'professional' assumed that certain codes of conduct and good practices were maintained by staff. However, if staff thought that they were responsible, that they had to make decisions for patients, they might not be able to cater for the individual needs of patients. Linked to this view was the notion that staff knew best and might even feel at ease to use any psychological or physical method to control patients. While the respondent recognized the appeals system as extending protection to the individual, there was a less-than-enthusiastic approach to patients' rights. 'If you get hung up on patients' rights you get what always sticks in my mind and is described as patients dying in the gutter with their rights pinned on their chests.'

The issues of protection for staff were interpreted as protecting staff so that they could carry out their duties in a professional and responsible manner. The idea of being professional and responsible meant that staff would be acting in the patient's best interest. Of course this is not necessarily so, as has been seen in recent enquiries into the mistreatment and abuse of patients by staff who claimed to be acting in the patients' interest. 'If you don't protect the carers, the carers will not act in the best interest of the patient.'

The role of the Mental Health Act Commission in the 1983 Act was recognized. 'I always think of the Mental Health Act Commission as being my conscience.' If the Mental Health Act Commission is the staff's conscience, then responsibility and professionalism become empty words because staff will be depending on an external body to see that they function in the patients' interest.

This respondent recognized clearly the role of the Mental Health Act Commission in helping to set standards for good practice. However, seeing the Mental Health Act as protecting society from the insane person fails to appreciate the powers of the agents of control of the insane within society. She strongly emphasized controlling the insane and taking away their rights, within the context of a parent-child model of relationships between caretakers and the insane. The role of caretakers is akin to that of parents who are held accountable, to a large degree, for their children's behaviour.'...I think that's very much the same for us in the care of the insane because if we are going to take away people's rights we've got to replace it.'

Although the concepts of team and multi-disciplinary working was thought to be positive ones, the doctor was definitely seen as the key member of the team who has the necessary knowledge and competence to diagnose insanity. The dominance of the medical model was seen as the accepted way of providing mental health care and treatment. Caretakers are the people who got the patients the right treatment. However, with the medical model being the dominant approach, any so called 'right' treatment could only be under the umbrella of the medical model.

This respondent felt that the services are not sensitive enough to the needs of women and black people. 'But when people talk to me about ethnic minorities and working with black people, and what are the problems, I get cross with them because I don't notice ethnic minorities and black people and Chinese people, and I get cross with them for bringing it up because in my mind I don't see black people I see them as my friends, somebody I like or somebody I don't like.' There was some recognition here of problems in seeing through the treatment and care of black people. But there was also some cultural stereotyping, as in the view that West Indians were seen as doing something which was normal when they smoked cannabis: 'What right do I have to stop them doing what to them is very normal? So that is an

infringement of their civil liberties.'

There was acknowledgement of the aggressive treatments in which some caretakers participate, and of the fact that such treatments may not always be in the patient's interest: 'I have always been aware of how aggressive carers can be perceived because of the really aggressive things we do. We put electric shocks in people's heads, we stick needles into them, we hold them down, we lock doors to keep them in and we say this is in their best interests, but you just imagine if you're at the receiving end.'

The issues of civil rights were seen as relevant in detaining people and so controlling their freedoms, and changing people's behaviours and way of life in ways which were considered best for them. 'What I think of I suppose with most horror in retrospect is lobotomy... at that period we never had any qualms about it.' There was a clear sense that most of these controlling activities are done without question. The respondent's explanation was that caretakers would see through those activities because they had to survive and not get into trouble. They had to follow the rules of the organization, fit into the team and not upset people. A major realization here is how much the caretakers are themselves controlled. Sexual rights of the elderly and the sexuality of patients are of concern. The feeling is that decision-makers in mental institutions are unable even to discuss these issues. The result is a situation where those rights are denied.

The concepts of insanity and caretaker were challenged. Insanity indicated that people were out of control. Preferred concepts were 'mental illness nursing' and 'mental health nursing', which saw people as being suffering, but in touch. The respondent argued that the concept of 'caretaker' gave the image of someone just looking after people and not involved in counselling and developing the individual. As a contemporary caretaker seeing the individual as suffering from a mental illness, mental illness and mental health

labels were appropriate. However, with the ambiguities in the public's and professionals' perceptions of people who behave differently, the words mad, lunatic, insane and mentally ill are still available and are used. The concept of caretaker was interpreted in its narrowest sense; a definition which extended care and involved providing opportunities for the individual to grow would have been preferred. While nurturing the individual to take responsibility for themselves, the concept would not embrace treating the person as a child.

Respondent C: A manager of a community psychiatric nursing service.

This interviewee saw mental health legislation chiefly as giving health professionals guidelines about how to detain people in mental hospitals, how to provide treatment, and how to prevent people being detained according to the whims of relatives. The interviewee reminded the interviewer that it was not so long ago that an unmarried mother could find herself being held in a mental hospital.

The 1959 Mental Health Act was considered to provide different sections covering the purpose of particular admissions, whereby people were being admitted for observation or treatment. The operation of the Act depended a great deal on the GPs' and consultant psychiatrists' assessments for decisions about admission.

The 1983 Mental Health Act was seen as extending the admission assessment to include social workers. This had resulted in a situation where people might not get hospital care or treatment easily enough. 'I think it is quite sad that we have to be with them until they probably run in front of a bus, or throw their child in the Thames, or what before we can do something about it and we know they need treatment.' There was some reticence in accepting social workers as apart of the admission assessment team. The social worker was seen as preventing people from getting treatment easily. Also there was a tendency to see delays in treatment as creating more

problems for the patient. Delays in treatment were instituted by the 1983 Act to ensure that the treatment was appropriate and that patient consent or a second opinion was sought. The involvement of social workers in the assessment and admission procedure raised questions about where the individual could receive the most appropriate care, as hospitalization might not be the most appropriate place. Of course, the new rules introduced by the 1983 Act frustrated doctors and caretakers who wanted to get on with detention and treatment, because they considered that they knew best. However, faulty assessment, diagnosis and treatment could be tragic for the person concerned. The Act was simply trying to ensure that the individual's rights were respected. It must be remembered that if emergency treatment was required, Section (62) allowed doctors and caretakers to enforce it.

Women were seen as getting a poor deal from the mental health services. 'They were deemed to be ill and then controlled when really it's a life problem.' Concern was also expressed about male doctors seeing women as neurotic, when in reality they needed support. Black people, in particular black boys, are experiencing pressure from the police who have them admitted as being mentally ill; those suffering from a mental illness are usually admitted compulsorily: 'Now those people who are indeed suffering from a mental illness, they are brought in on a petition while their English counterparts are not.'

This respondent felt disappointed that in the care and treatment of the mentally ill caretakers sometimes participate in mechanical and violent methods of dealing with people, that massive doses of drugs are used and more people with mental illnesses are not being cured.

Respondent D: A teacher of mental nursing in a hospital training school.

Mental health legislation was seen as ensuring that people are cared for when they cannot take responsibility for themselves, and when staff want patients

to comply with what they want them to do. For example, '...people will quite often comply in taking medication or being admitted to a ward or whatever, knowing that if they don't they will be sectioned.'

The Mental Health Acts were seen as ensuring that patients' rights were upheld. The Acts defined client groups and so affected directly the way in which mental nurses work:

'The 1983 Act was heralded as taking care of the rights of clients more seriously, giving clients more civil rights. That was certainly the way it was sold to us. I am not sure whether that is true.' At the same time the Act gave caretakers the power to detain people in hospital: 'I think it is a social control situation, I think it affects your ability to have a therapeutic relationship.'

The argument being presented here was that, while the 1983 Act was talked about as ensuring patients' rights, it also included a new section (section 5) which gave caretakers the power to detain the patient. Such a detention power should only be used by the caretakers if no doctor was available. There was an issue of social control by the caretakers here, because if the person was not detained compulsorily he/she should be allowed to leave. If caretakers can prevent someone exercising this right, there is the possibility of people being detained when this is not necessary. On the other hand, if this holding power is used constructively someone requiring care could receive it.

The respondent saw the Mental Health Review Tribunals and the Mental Health Act Commission as ensuring that patients can appeal against the decisions to detain and treat them. There were, however, reservations about the working of these bodies: 'It's difficult for anybody to take things to the Review Tribunals and then, even when they do, it's their word against the right

and power of the psychiatric system, so they were unlikely to succeed. The right to complain was more available but whether anything happens because of that complaint or any change to anything, well I don't know, probably things haven't changed much...The Mental Health Act Commission created excitement in that notices were put indicating that they were coming and would see people. They were heralded as the great liberator of the mentally ill, but one wonders how practice differs or whether it differs.'

The respondent saw much of the mental health service as a system of social control. Examples are, 'In the care of the elderly, the use of sedation and night sedation and things like that for ward management'. The mental health system was considered as sexist and racist: 'In the inpatient situation there were very few black people and I think that, that in itself was significant, it was a very specialized ward which was seen as prestigious, you know labels such as being "intellectual". There must have been black people who would, you know benefit. But I don't know whether they were not referred or once referred were not admitted... When I was working in a MIND hostel, at the time they were all men in the hostel and the men were requesting and I think the people on the management committee thought they should have a woman to come and live in the hostel, because it would be nice to have somebody pretty around, who could sort of do the washing up...I think I find that very frightening; we all know what goes on in the grounds of psychiatric institutions, abuse, rape for cigarettes etc.'

Psychiatry and caretakers were seen by this respondent as participating in a 'mass abuse of power': 'They just seem to treat the people they are working with as just appendages to the ways in which they can display their ego strength or booster up themselves'.

Caretakers are under-estimating people by not thinking of them as responsible for their own actions. So they are not given the respect required.

Nor are they given accurate feedback about their behaviours.

Respondent E: A teacher of nursing.

Mental health legislation was seen as providing care and treatment for very distressed people, by allowing people the opportunity to have skilled help. The respondent considered the 1983 Act as having more written rights for patients compared to the 1959 Act. This was considered a good development because patients were given details of their rights which they could refer to; this has resulted in staff being more aware of what patients say, and patients knowing how and where to institute an appeal.

The respondent considered that medication is a major area of social control: 'Who gets medication and when they get medication is still an issue'. Women were seen as getting a male-dominated service: 'The other thing is, it's very rare for any woman, particularly when it's mental health, to actually express a wish to be treated or examined by a woman'. Black patients were felt to be invisible in the service where this respondent worked: 'I have this nagging suspicion that perhaps we're not offering the service. I can't believe that there aren't people within the black community that need psychiatric care. Because there are so many cultural differences I have a belief that we might not be able to understand their language of distress'.

Respondent F: A clinical mental nurse specialist in substance abuse.

This respondent saw mental health legislation as protecting the individual from self-harm and from harming others, and as providing a guide for action during a crisis. The 1959 Mental Health Act was viewed as rigid and inflexible, with no room for the individual to question. Nor was there flexibility within the institutions; caretakers themselves were inflexible. The 1983 Act improved on this, by offering more flexibility and better appeals procedures, which have contributed to more successful appeals.

The new powers and responsibilities of caretakers under the 1983 Act were seen as a positive move. The ability to detain someone in hospital, the respondent offered, 'Would test their clinical and practical judgement'. Caretakers were considered to be still not enabling people to have their rights. This situation, the respondent felt, was due to caretakers being poorly informed about the rights of patients enshrined in the 1983 Act. The respondent argued that, if caretakers are not aware of the details of mental health legislation and the rights individuals have under the 1983 Act, they can hardly enable individuals to demand their rights.

Language was seen as an aspect of social control, because the language doctors and caretakers used to describe a person's behaviour differed greatly from how that person might see himself/herself. The respondent viewed this as a major rights issue, because how the person saw themselves was not taken into account when decisions were being made. This respondent felt that women are not taken seriously: 'It's a very distinct way of making sure they don't gain power that they are not informed'. This situation was seen as similar for black people and lesbians. Yet, 'These words are used at team meetings and conferences, and you sit there and think, they said it again, but you don't see them take any action. Nobody actually says, "What are you going to do"?'

Respondent G: A teacher of mental nursing teachers.

This interviewee saw mental health legislation as providing a broad umbrella for patients' safety and protection, and also a framework for the delivery of care which ensured certain standards, including that caretakers themselves were provided with guidelines and some boundaries in which to function. The Acts allowed patients to go into hospital of their own volition, knowing that after a period of time they were not likely to remain institutionalized without some form of review.

The Acts from 1890 to 1983 were seen as progressive in relation to patients' rights. Patients and relatives were given more information concerning their rights in hospital, and the appeals procedures available to them. This progression, the respondent considered, can be seen in the terms used to describe people with behaviour problems. The concept of the 'insane' person has been challenged, as being too narrow a concept, and the preferred concept is mental health. However, given the ambiguities concerning mental disorders, the concepts 'mad', 'lunatic', 'insane' and 'mentally ill' were still used: 'I think mental health is more broader... I worry about the word "insane" and the amount of stigma attached to this word'.

Control issues in the psychiatric services were recognized, but the respondent felt that the control which caretakers maintain is a good thing. The respondent took for granted that caretakers are always controlling individuals in those individuals' best interests. Issues of rights were recognized, and, in particular, the Mental Health Review Tribunal was mentioned, but this theme was not elaborated.

Respondent H: A teacher of mental nursing and a counsellor.

This respondent felt that most of the conditions for patients outlined in mental health legislation were not actually offered.

There was a strong sense that the control and the services offered to the mentally ill were socially acceptable; such legislation was seen as making mental health care available to all: 'People having access to care and not having have to worry about whether they could pay for it all or not'. The view was expressed that caretakers being able to lock the door on patients was therapeutic, and the open door policy was not necessarily so.

The 1983 Act was seen as being more in favour of patient's interests, as it ensured that their treatments and medications were reviewed every three

months, and it also provided for a second opinion through the Mental Health Act Commission. But the actual institutions were seen as not giving the patients the rights of dignity and respect, because usually the environment was dirty, and in need of decoration. While the custodial functions of caretakers were re-organized, caretakers were seen as agents of change rather than agents of control. They are involved in therapeutic activities and only a minority are abusing their role and power: 'A chap that I knew when I did my secondment, had come straight out of the Royal Air Force. He had no training as no training was needed to be a charge nurse when he started. He would eat, take his choice of the patient's food before it was dished up, and there was one patient who's behaviour due to his illness was obsessional in cleaning up for everyone, and if another patient was incontinent in the dormitory then this guy was brought back from his industrial therapy to clean up the mess, so exploiting his illness'.

The respondent talked about the relationship between male and female caretakers and between male doctors and female caretakers. Male caretakers were seen as macho, very big, wore big boots and had big clanking keys and strutted around. Female caretakers were seen as soft and maternal. Male doctors were seen as wanting to get their own way, especially when a female caretaker was in charge of the ward.

Concerning black people, the respondent felt that there were problems: 'It makes one wonder if they had someone to talk to from their own culture, or just being allowed to express what they were expressing they would have avoided the need to come into hospital'.

Respondent I: The author's personal reflections.

My own background as a Registered Mental Nurse gives me familiarity with most of the situations mentioned by the respondents. This familiarity will naturally have had some effect on the way in which I collected and interpreted

the research data. As Cicourel (1964) argued, interviewing is a method in which the activities of the investigator play a crucial role. As a way of documenting my own input to the research, I have also attempted to answer the interview questions.

'Between the years 1967 and 1979 I worked as student mental nurse, staff mental nurse, charge mental nurse and senior charge mental nurse. I wonder sometimes whether I can consider the period as a student to be working with the insane, because all I can remember doing was carrying out the doctor's orders and the organization's rules and regulations. Also, given the hierarchy in the mental hospital, I did not question enough, or entertain anyone else questioning, what we were doing. Since 1979 I have been working in education, where I have been involved in some teaching on mental health issues to nurses, social workers and health educationalists.

The mental health legislation to me provided a framework within which doctors can diagnose and treat people medically for their illness and behaviours. It helps to determine the relationships between patients and clients, including with social workers, and doctors and nurses, and all the health and welfare workers patients are likely to meet. I thought the legislation allowed individuals who needed care and attention to have such care. There was a need for such Acts to ensure that the individual received care and attention. What I feared was that sometimes this was taken for granted, particularly if health and welfare staff were not careful in how they used the Acts. I am thinking here of how the Acts could be used vis-a-vis children, the elderly, working class patients, women and ethnic minority groups. I think there are problems in the way in which the Acts were interpreted by caretakers, because their training was limited in this area, yet their contribution to the decision-making process could have had dire

consequences for patients. The use of the Acts and the degree of compulsion which came with them meant that caretakers could hold individuals and insist that they take certain treatments or drugs. It can also mean that patients can be held against their wishes and so forced to stay in hospital and to receive drugs.

There is a need for caretakers to understand the relevant legislation, because they are the persons who will see through the prescriptions of the doctors. It is the caretaker who will give and maintain the drugs. It is the caretaker who will restrain the person deemed to be mentally ill, and who will report to the doctors as to how the person is behaving, and this can result in changes in treatment which might affect the individual's rights. It is the caretaker who manages all the domestic arrangements on a ward, and so can enhance or restrict rights. The caretaker also sets the tone of the ward environment, and this can affect the way in which people are cared for and treated. It is important not to forget the reports and enquiries into abuses of the mentally ill, and even the deaths which were happened under suspicious circumstances. For example, the Ely Hospital enquiry 1969 discovered: (1) Cruel ill-treatment of four patients by six named members of staff; (2) General inhuman and threatening behaviour towards patients by one of the staff members; (3) Pilfering of food, clothing and other items belonging to patients; (4) Indifference on the part of the chief male nurse to complaints; (5) Lack of care by the Physician Superintendent and other members of the medical staff. The Farleigh Hospital inquiry in 1971 investigated the ill-treatment of patients and violence to patients. This enquiry resulted in nine nurses being charged with offenses relating to cruelty. Six were acquitted and three were found guilty and received sentences of imprisonment. This hospital was known for its heavy-handed attitude towards patients. The Whittingham Hospital Report in 1972 was initiated when two senior members of staff complained directly to the Secretary of State for Social Services with allegations of ill-treatment of patients, fraud and maladministration, including

the suppression of complaints from student nurses. The enquiry uncovered financial irregularities and victimization, and two nurses were convicted of theft. Shortly after the police investigations, a nurse assaulted two patients, one of whom died. The nurse was convicted of manslaughter and imprisoned.

The 1959 Act protected caretakers from prosecution (section 139) provided they had acted in good faith. Staff were expected to provide a safe and therapeutic environment. They were responsible for the cleanliness of the wards. They saw to it that medicines were given as prescribed. Caretakers were responsible to the hospital managers. They had to adhere to the procedures and policies of their employing authority. They had to ensure that the care they provided was in line with the prescriptions of the psychiatrist. They were part of the multidisciplinary team responsible for care and treatment. They protected patients from racial or sexual harassment, and from being aggressive and or violent to each other. They carried through a variety of therapies from group discussion to individual counselling. They organized the day so that patients received therapy, rest and entertainment. They maintained the rules of the institution, for example not allowing drink or drugs on the premises. Caretakers working as community psychiatric nurses provided care and treatment in the community. They visited patients in their homes and in day hospitals, maintained medicines and gave intramuscular long-acting medications. They ran support groups and offered individual counselling sessions. They also provided a variety of therapies to individuals and groups in the community, such as behaviour therapy and cognitive therapy. For patients in hospital caretakers were the planners of the 24 hour care and treatment day. Essentially they were responsible for ensuring the safety of the patients.

Concerning patients' rights, caretakers must ensure that the Mental Health Act of 1959 is interpreted so that individual rights were not abused. They must

be aware of the distinctions between 'formal' and 'informal' patients, and the associated rights of the individual admitted informally or formally. For example, they had to ensure that patients received their visitors, and that they received and could send out their post and that patients' property was safely looked after; they were responsible for making sure that patients were not abused with medicine by over-enthusiastic doctors or nurses. They acted as patients' advocates, and provided a listening ear. They also had to ensure that the papers for sectioned patients were properly filled in and that the duration of sections was known; that clear guidelines for complaints and questions existed; that records and notes of all the activities and happenings on the ward were maintained.

The 1983 Act made the caretaker for the first time able to keep a person in hospital. Section (5) allows the mental nurse to keep someone detained against his or her will for up to 6 hours until the doctor responsible can make a decision with the multidisciplinary team as to whether the person can be discharged or not. The 1983 Act spelt out new responsibilities for the managers, for example managers were now required to give the patient and his/her family full information about his/her status while in hospital. The caretaker as advocate for the patient must ensure that these new rules were maintained. If there were any complaints or refusal to co-operate on the part of the patient, and if the Mental Health Act Commission was called, then the caretaker could be asked to be a member of the panel which looked at the practices of the institution.

The 1983 Act reminded caretakers of the rights of patients receiving care and treatment. In instances where a second opinion was required, this must be truly a second opinion, given by a doctor approved by the Mental Health Act Commission. Patients may have access to a legal representative paid for by themselves, their relatives or by legal aid. Admission for observation must be for observation only, treatment must not be given on an observation order

except as a one-off emergency treatment. A treatment order, although allowing treatment, must still adhere to the consent and second opinion rules. The second opinion rule was available for drug treatment, ECT, for implants and for psycho-surgery. Patients and their families must be told how they can get in touch with the Mental Health Act Commission and the Mental Health Review Tribunal.

The Community Care Act 1991 makes it explicit that in the future community care for the mentally ill must be developed. The Act asks for a tightening up of the procedures when a mental patient is discharged from hospital. The discharge procedure should ensure that there is a named mental health professional assigned to the patient.

The main social control aspect of caretaking work was concerned with medication, privacy, providing care for black people, working class people, disabled people, women and gay people. Medication, I felt, was given for therapeutic reasons and also to keep patients quiet and cooperative because there was usually too few staff to offer therapy to all the patients in a ward.

Patients usually have little privacy in the wards. Here I am referring both to privacy between same sex patients and between males and females. For example, in dormitories both social space and privacy were limited. In the wards should a male or female patient become overactive and take off his/her clothes then the whole ward is available to look at him/her. Black patients do not receive a sensitive enough care approach. They usually receive large doses of medication and ECT, rather than opportunities to talk through their problems. Women patients are similarly not listened to, so their unique problems may go unheard. Gay and lesbian patients have difficulty talking about their relationships and problems because the staff are constantly trying to pressure them to change. Staff also make unpleasant remarks about gay and lesbian patients and treat their sexuality either as a joke or as a social problem.

The emphasis in the training I did, and in the textbooks I read, was on listening to patients and establishing relationships to enable the patients to make their own independent decisions. However, the work situation was filled with administrative tasks and the need to maintain the rules and regulations of the institution. I have always felt that there was too little time left to be with, and to listen to, patients. Much of my time was spent opening doors, locking doors, saying "you can do this" or "you cannot do that" and giving medicines. I think in some instances I had to appear to be busy, moving constantly throughout the ward, rather than being with the individual patient. In general, the expectations I had were only partially fulfilled. I had to be constantly balancing the time available to listen to patients against the time used doing domestic chores.'

Discussion of contemporary caretakers' views

It is evident from the interview data that power and powerlessness are central in the provision and use of mental health services. For the caretakers providing services, the exercise of professional discretion and judgement involves the use of power over fellow citizens who turn to them for help.

Overall most of the contemporary caretakers expressed the following: mental health legislations provided for the care and treatment of the insane; mental health legislations were a major social control process for the insane; important changes in the role of caretakers were brought about by the 1983 Mental Health Act. A minority of contemporary caretakers saw mental health legislations as protecting individuals from self harm, protecting caretakers from liability and contributing to the maintenance of social control. All the contemporary caretakers interviewed agreed that mental health legislations asks for the rights of patients to be respected. They saw such legislations as protecting patients from the potential abuse of their rights and protecting staff from litigation when working with patients. Patients' rights were seen as being protected through the admission procedures, the consent to treatment rules,

the provision of appeals through the Mental Health Review Tribunal and the functioning of the Mental Health Act Commissioners.

While their main observations of mental health legislation were positive, some of the respondents felt that the 1983 Act, by emphasizing the rights of patients, might in some cases result in patients not receiving treatment early enough. They expressed the view that the shift from the medical dominance in care and treatment of the 1959 Act, to the more legalistic approach of the 1983 Act, resulted in difficulties for caretakers. These difficulties they saw as being bound up with the administration of legal procedures, particularly those associated with the holding powers of caretakers, which some felt was an unnecessary development. Perhaps it is difficult for contemporary caretakers to recognize and articulate their social control functions.

Caretakers were seen generally as acting in the best interests of the patients. Some respondents, however, felt that faulty assessments and diagnoses did occur, and that these sometimes have tragic consequences for patients and their relatives. Some felt that the use of the 1983 Act holding power could result in patients being detained unnecessarily. Reservations were also expressed about appeals to the Mental Health Review Tribunal. These were that such appeals were unlikely to succeed, as it was the patient's word against the right and power of the psychiatric system.

It was felt that who received medication, what amount they got and when they received it was a main area of caretaker social control. Language was felt to be a barrier to effective relationships and the ensuring of rights of patients. This was considered to be evident in the medical and technical language of caretakers and doctors which described the person very differently from how the person saw himself/herself. Caretakers were thought of as withholding patients' rights because they were not fully aware of the details of the various mental health Acts and the rights enshrined in those Acts.

All the respondents expressed an awareness that women, black people and people with different sexualities did not receive suitable care and treatment. They thought this problem was generally recognized but no constructive approach was taken to provide effective care and treatment for these groups. Interviewees felt that the expectations which they had when they started training were frustrated as they saw much of the work to be custodial, mechanical, and task-orientated, and to include violent ways of dealing with people.

The contemporary caretakers' views and much of the evidence found in researching this area highlight questions of liberty versus therapy, care and treatment within psychiatric services. Since the 1950s, psychiatry has received much critical questioning as to rights, liberties and justice. The caretakers interviewed recognised that patients sometimes lose merely as a result of their admission many of their rights that should accrue to all citizens. The rights debate is alive and well with caretakers. They also demonstrated their awareness of the subjective nature of psychiatry and of cross-cultural variations in concepts of health and illness. The caretakers saw as treatment being imposed on patients in varying degrees, forms and quantities. While they were critical of treatment regimes, they were mindful of the need to treat in order to prevent patients deteriorating, and exposing themselves to danger or to being a danger to others. They saw any rights debate which interferes with the clinical role as denying patients access to necessary treatments. What caretakers did not want is for the mentally ill to be aimlessly walking the streets, being decarcerated to accumulate in ghettos, exploited by private landlords and dying 'with their rights on'. On the other hand, the caretakers felt that the rights approach, while seeking to reduce the powers of medicine, appears to be extending the powers of social workers and caretakers. They saw themselves as intermediaries between doctors and patients, and between family members and doctors, and as general defenders of patients against the prejudice of their colleagues and the public. They voiced the

difficulties the patients faced but did little in a practical way to alleviate the problems.

It is clearly a substantial task to challenge the power of the medical system and the psychiatric profession. The men and women working with the mentally ill at the end of the twentieth century represent an educated and critical group. All the approaches students learn must now involve users. For some caretakers user involvement is an empowering and exciting potential for improving services, for others it is a threat to their role. Mental health legislation was seen by the contemporary caretakers interviewed as providing for care and treatment, maintaining social control within the mental health services and protecting patients' rights.

CHAPTER 11

DISCUSSION

The people who maintained the twenty-four hour care of the insane between 1890 and 1990 were known as keepers, attendants and mental nurses. These changes in their job title reflect the changing roles which they performed during the period under study. Many of the changes in their role and functions were brought about by developments in mental health legislation. This chapter summarizes the overall effects of such legislation on the work of caretakers and the rights of the insane, drawing on both the historical and the contemporary data collected in the course of the study.

Mental health legislation, medicine and changes in caretakers' work

The Lunacy Act of 1890, the Mental Treatment Act of 1930, the Mental Health Act 1959 and the Mental Health Act 1983 all brought about policy changes which affected the work of caretakers and the rights of the insane. Associated with changes in caretakers' roles were shifts in both medical and public perceptions of mentally distressed persons. This is most clearly seen in the changed labelling of such persons, from 'lunatic', 'mad' and 'insane' in 1890 to 'mental illness' in 1930 and 1959, and 'mental illness' and 'mental health problems' in 1983.

By the middle of the nineteenth century, a system of institutions had been set up to control, care and treat the insane. The caretakers were not a highly trained workforce, they were poorly paid and worked under conditions of severe discipline and rules and regulations. Their daily work routines were not dissimilar from the lives of servants in great country houses; many were demobilized soldiers accustomed to giving and taking orders within institutional life. On the shoulders of these ill-equipped caretakers fell the problems of carrying out difficult tasks in a conflictual context. These conflicts related to caretakers' role in providing care and cure, on the one hand, and

secure containment, on the other. Other problems for caretakers were whether they were domestic labourers or carers, or mainly concerned with treatment, control and punishment.

The Lunacy Act of 1890 required caretakers, then called asylum keepers and attendants, to supervise and exercise the insane inmates in accordance with the rules and regulations of the asylum. The attendants kept the institution clean and tidy, maintained order by controlling the inmates and functioned as the medical superintendent's servant. This period saw a shift in public thinking about madness, with madness being seen less as a disease related to the possession of devils, and more as a physiological state. With this thinking came the development of the asylum system to replace the haphazard mixture of private madhouses, public workhouses and prisons. At this time there was some training for caretakers in some asylums, but this varied and depended on the views and beliefs of the medical superintendents.

The asylums did not bring about the promise of cure, but instead became establishments which exercised control. There was a strong emphasis on the orderly management of caretakers and the insane. The caretakers had to abide by the strict rules and regulations of the institution, and the idiosyncrasies of the doctors and the superintendents.

The Mental Treatment Act of 1930 was passed within a climate in which politicians viewed mental illness as being similar to physical illnesses. They held the belief that such a view would minimize the stigma of mental illness. Politicians were also concerned about the need for a more humane approach to the mentally ill, and the development of a system which would ensure that the individual's rights were respected. In line with this thinking, the politicians argued for an Act which would place the treatment, care and control of the mentally ill with doctors rather than with magistrates. The policies which were

developed emphasized that mental illness could be cured, and that community care should be established. The shift to community care was based on the idea that it was better for people to be treated in their own homes, and that this would be cheaper than hospital care. Attempts to cure mental illness saw the vigorous use of insulin therapy, ECT, psychosurgery and drug therapy. Caretakers were therefore faced with claiming, on the one hand, that they were engaged in treating curable illnesses, while, on the other, believing that patients were suffering from hereditary conditions which had a poor prognosis. In reality, most of the work of caretakers was concerned with custody and control, and involved straitjackets, padded cells, forced feeding, exercise, farm and industrial work and surveillance.

The clinical-somatic approach of the 1930s saw mental illness as a disease with physical causes. The dominance of this approach was related to developments in science and technology and the professionalization of health and welfare. In the nineteenth century, medicine was hailed as capable of curing a number of physical illnesses; the promise of scientific discovery was extended to psychiatry (Scull 1974).

These changes also brought developments in the training of caretakers. Books were published and courses and examinations were developed to reflect the changed and changing work and role of caretakers. The training conformed to the General Nursing Council's training scheme for general nurses. It reflected the new emphasis in the work of caretakers which took on a more somatic approach. Caretakers implemented the treatment regimes of the doctors, kept patients under observation and reported the patients' conditions to the doctors. They were expected to be skilled in the following treatments: sedation, relaxation, insulin therapy, pyrotherapy, malaria and sulphosin therapy, diet and vitamin therapy, endocrine and drug therapies, operative intervention, rehabilitation, psychotherapy, massage and hydrotherapy. But along with those mainly physical interventions, caretakers

still entertained patients, shared in domestic chores such as polishing the floors, and spent long hours with patients in the airing courts. The change in caretakers' title from 'attendant' to 'mental nurse' was also completed during this period.

The 1930 Act saw the introduction of the Board of Control which was established to consider appeals from patients and to visit asylums, hospitals and private madhouses, to enquire into aspects of the running of such institutions and the rights of the people incarcerated as being mentally ill. The Act introduced the categories of 'voluntary' and 'certified' patient. Voluntary patients were admitted of their own volition, and certified patients were admitted by the recommendations of two doctors. Voluntary patients not only had the right to decide on their admission but could in principle decide on the termination of their hospitalization.

The 1959 Act consolidated all the previous mental health legislation and brought in changes which affected the rights of patients and the work of caretakers. The Act resulted in a reduction in the numbers of people being admitted to mental hospitals. This was achieved through the challenge to institutional care, increased pressure to admit people voluntarily and increased access to the Mental Health Review Tribunals. Although patients in theory had access to tribunals, the delays before cases were reviewed led to questions as to whether they were getting a fair deal. Within the area of care and treatment, the somatic approach became more dominant, with doctors enjoying more control in all aspects of the institution.

Outpatient clinics were well-established and greater use of occupational therapy was evident. Many more psychiatric wards were established in general hospitals. Community care became a key word, and this was provided as a mixture of domiciliary visits, social clubs for ex-patients and an emphasis on early admission and early discharge. Psychopathy as a mental

disorder was added to the classification of mental disorders, the formality in the admission of voluntary patients was reduced and the Board of Control was abolished to make way for the new Mental Health Review Tribunal.

The Mental Health Review Tribunal had jurisdiction to review the application of compulsory powers subsequent to admission, and afforded discharge to the Responsible Medical Officer, the hospital managers and the nearest relative. Patients could now be admitted to any hospital or mental nursing home without formalities. They could be admitted for observation or for treatment. Guardianship was introduced, and this meant that patients could remain in the community and be supervised by a named local authority worker, usually a social worker. The 1959 Act presented a completely anti-legalistic approach to insanity, dispensing with all the judicial roles around commitment.

This period saw an influx of psychologists in mental health care. According to Ramon (1985) psychologists started to contribute to soldiers suffering from shell-shock during the first world war 1914-1918. However clinical psychologists as a group were not employed until 1928, when Ms Baldwin, a student of Cyril Burt was employed by the Tavistock Clinic. They mainly followed a psychoanalytic approach which emphasized a focus on individuals, their unconscious and emotional life and childhood relations with parents. This approach saw mental disorders as the result of unresolved emotional conflict, and accepted hereditary factors as one basic cause of mental illness.

With the second world war came a boom in psychologists working in child guidance clinics, hospitals and outpatient departments. Their work involved personality- and intelligence-testing and psychotherapy. The power of psychological testing gave psychologists a new role within psychiatry. Psychiatrists used the tests to aid their diagnostic and intervention processes. At the same time, psychologists were developing their own intervention

programmes, such as behaviour therapies which became part of the treatment available.

The 1983 Mental Health Act moved the approaches to care and treatment towards a more legal and rights arena, which, while not reducing the clinical-somatic approach, attempted to increase the civil rights of patients. Social workers were now to be more involved in admission procedures. The Mental Health Review Tribunal was required to respond more rapidly. A new body, the Mental Health Act Commission, was established to ensure good practice and to make sure that the procedures for consent to treatment and second opinion rules were followed. Caretakers were given new powers to detain patients in hospital.

Contemporary caretakers feel that the 1983 Mental Health Act has generally led to better protection for the rights of patients. But they also see these changes as inhibiting to some degree patients' rights to care and treatment. They are concerned about the rights expressed in the 1983 Act and the difficulties which are still evident in ensuring that those rights are achieved.

Caretakers have remained central to the running of hospital wards, and only a minority have become involved in community care. The clinical-somatic approach to care has resulted in most of the caretakers' functions being concentrated on maintaining medication. However, these same changes also made possible the development of new caretaker skills such as group work, therapeutic community skills, counselling skills and psychotherapy skills. The result is that caretakers are once again emphasizing their role in developing interpersonal therapeutic relationships with patients.

Power, social control and caretakers' work

This study has focused on the job title of caretaker, as a concept which embodies the care, custodial and social control functions of people who look

after the mentally distressed. The concept emphasizes caring functions which goes beyond medical care and treatment. For caretakers, the medical care and treatment which they offer is equal to their other functions. Those other functions have historically included: the social control of the insane, the madman/madwoman or the mentally ill person through the rules and regulations of the institutions in which caretakers work; the patience to support someone who is mentally distressed; using time productively in the work situation to enable people to come to their own decisions and take responsibility for themselves; and encouraging people to be open to new insights and so to grow.

The evidence drawn on in this study demonstrates that the provision of services for the insane has meant that both the people deemed to be insane and that caretakers have been subject to social control within institutions. The nature of this control has embraced the social for the caretakers, and the social and the medical for the insane. The government, through mental health legislation, has sought to maintain the social control aspect of mental health care both in institutions and in the community. But this state approach to the insane, while providing caring services, has at the same time tended to encroach on the civil rights of the individual.

Drawing on the work of Illich (1976), it could be argued that the insane are subjected to social control through the ways in which doctors and caretakers exercise power over them. The insane are cast in a passive role; they are labelled and treated as inactive subjects. Treatments are carried out by doctors and nurses who are involved in power and social control relationships with the insane. Following Weber (1949), these power relationships mean that some people in relationships are able to pursue goals despite the resistance of others. Caretakers were seen by the superintendents and the doctors as both obedient servants of the institution and servants to the insane, as rule-keepers and rule-enforcers. Caretakers

were required to keep to the rule-book or risk dismissal.

The contemporary caretakers interviewed recognize their treatment and social control functions. They see the mental health services as protecting the individual from self-abuse, but they are also aware of the abuse of the rights of the individual within these services. They see some of their caring activities as involving negotiation with the patient, but the main aim of their work is to ensure patient compliance. Social control is an important element in the structure of mental institutions, and the legitimation of social control is an important part of the process of professionalization.

The social control functions of caretakers of the insane embrace the social control functions of medicine and the medicalization of behaviour. Conrad and Schneider (1980) argue that there are some benefits in the social control of behaviour through medicine. It provides for a humanitarian approach to the control of the insane which is not retributive nor punitive, but ideally therapeutic; it increases tolerance and compassion for human problems. According to Zola (1975), medicalization results in prestige for 'scientific' treatments, particularly if these prove successful. The use of the label 'sick' allows for the conditional legitimation of insanity, and leads to an optimistic view of outcomes and the possibility of a cure. Medical social control may circumvent legal and judicial procedures, and may be applied more informally. Conrad (1975), on the other hand, sees social control as removing responsibility from the individual; treatments are cloaked in the mantle of science and it is wrongly assumed that medical intervention is objective, value-free and morally neutral. What medical men and women do is effectively mystified and removed from the arena of public debate; insanity and other behaviours are defined as a medical problem requiring bodily manipulation; social problems are individualized and their causes are seen as lurking in the individual rather than in the social system. The net effect is that behaviour problems are depoliticized, and political protest is neutralized because it is

itself rendered symptomatic of mental illness.

Susan Sontag (1978) has suggested that illness is used as a metaphor for various kinds of social problems. We use its medicalization to detract us from looking at the social structures and the social conditions which play a significant part in causing and maintaining social problems.

The rights of the insane and caretakers' work

Psychiatry depends on the judicial system to confer legitimacy on its activities and so give doctors power to control the disruptive individual. The history of mental health statutes is that these imposed a duty on authorities to provide asylums and enabled legal, medical and lay personnel to scrutinize the conditions prevailing in asylums and madhouses. The 1890 Lunacy Act saw the Lunacy Commissions' functions expanding to being a legal watch-dog and administrative overlord of the admission and treatment of the insane. The background for this expanded role came from the popularity of the Moral Treatment and Non-Restraint movements and the work of Lord Ashley in Parliament. Thus in the rhetoric of the period the Lunacy Commission should strive to protect the insane from exploitation, abuse and inhumane treatment. The 1890 Act placed emphasis on the frequent and detailed visitation of all places in which the insane were confined, with power given to the Lunacy Commission to discharge or sanction a probationary release; to ascertain that no persons were improperly confined; to release patients no longer dangerous to themselves or to others and not likely to benefit from further treatment; to maintain an open-door system; to provide occupation and amusement; to insist on the submission of monthly reports and on medical certificates for each mechanical restraint; to ensure greater rights for the insane with regard to their correspondence; and to institute the ruling that any person could have an insane person seen by two medical practitioners and then discharged with the consent of the Lunacy Commissioners. However, in the main the Act was designed to protect private insane persons. Such

persons could be confined only if an order was signed by a Magistrate or Justice of the Peace specially appointed by the Secretary of State, unless it was an emergency, in which case one medical certificate was appropriate, or unless the person was found to be insane by inquisition. The Lunacy Commissioners were also able to enter and survey charitable and religious institutions.

The period in which the 1890 Lunacy Act was designed saw a great deal of activity from three organizations which were prominent in working for the reform of mental health legislation. These were the Lunacy Reform Association, The Lunacy Law Amendment Society and the National Association for the Defence of Personal Rights. In 1913 the Lunacy Commission was replaced by the Board of Control. The 1930 Mental Treatment Bill was passed after extensive debates in Parliament. Members argued that patients needed protection against themselves and against their relatives. They questioned the power of the Board of Control and the poor conditions under which the mentally ill lived in asylums. Members were concerned that patients were hospitalized as a result of misjudgment and misapplication of diagnosis. The Report of the Royal Commission on Lunacy and Mental Disorder chaired by the Rt. Hon. H.P Macmillan proposed that civil legislation for the mentally ill should be replaced by medical authorization. One factor which contributed to the reversal of the legalism of the 1890 Lunacy Act was the increasing prestige of the medical profession. Other factors included the development of social work, occupational therapy, psychology and the training of attendants. There was concern that the rights of the patient must be protected, along with the rights of the public. The asylums were now re-christened mental hospitals, the insane were referred to as patients, and the drive was towards informalization and voluntarism.

This period saw the development of clinics for mental disorders associated with general hospitals and medical schools. These provided for early

treatment, education and research. Patients were admitted informally or formally and their admission depended on medical recommendation. The initial period of a compulsory order was six months, and this could be extended with the permission of the Board of Control. The Board of Control visited and reported to the Ministry of Health on the state of hospitals, clinics and private madhouses. These changes resulted in caretakers being trained in the techniques associated with physical treatments for the mentally distressed, such as psychosurgery, ECT and medication. They were also required to provide programmes to re-socialize patients, to provide for their entertainment and to engage patients in worthwhile activities such as tailoring and dressmaking. At the same time the developing hospitals were being built with large farms which provided occupation for the staff and patients and a sense of a self-contained community.

The 1959 Mental Health Act's main intention was to free all but a few patients from compulsory detention and treatment. The Act abolished the Board of Control and established the Mental Health Review Tribunal. With the introduction of the National Health Service, the Minister of Health became responsible for the control and supervision of local authority services, of all National Health Service hospitals and clinics and for licensing all hospitals outside the National Health Service. The Board of control, although responsible for all matters affecting the patients and their rights, had powers which were largely advisory. The Royal Commission on the Law relating to Mental Illness and Mental Deficiency (1957) favoured the abolition of the Board of Control. The 1959 Act brought the Mental Health Review Tribunal, which consists of three members - a doctor, a lawyer and a lay member. It functions as the body to which certain compulsorily detained patients can apply to for discharge. A patient or his/her nearest relative can only apply to the Tribunal at certain times. If the patient is detained under Section 26 of the 1959 Act (admission for treatment) he/she may apply to the tribunal within six months starting at the date when the Section came in force. A patient under

guardianship may apply within six months of the starting date. If a patient under Section 26 is re-classified as suffering from a mental disorder which is different from the one specified on the application form, the doctor must inform the hospital authorities which must in turn inform the patient and the nearest relative; the patient or the nearest relative may then apply to the Mental Health Review Tribunal within 28 days of receiving the information. If a patient is transferred from guardianship to hospital he/she may apply within six months of the transfer. A patient detained under Section 60 can apply within six months starting at the date when the Section came in force. Any patient detained under Section 65 cannot write directly to the Tribunal, but can write to the Home Secretary asking him/her to refer the case. The Home Secretary must refer the case within two months of receiving the request. The nearest relative can order the discharge of a patient by giving 72 hours notice to the hospital managers. If the Responsible Medical Officer overrules on the grounds that the patient is dangerous, the nearest relative can apply to the Tribunal within 28 days of being overruled.

Under Section 123 of the Mental Health Act 1959, a Mental Health Review Tribunal can direct the discharge of a patient. It must be satisfied that the patient is not suffering from mental illness, a psychopathic disorder, subnormality or severe subnormality; and that detention is not necessary in the interests of the patient's health or safety or the protection of other persons. This period saw caretakers as involved more on the level of physical treatment and the maintenance of institutional life. At the same time the new emphasis on community care brought the development of community psychiatric nursing. There was a realization that the structure and organization of the hospital has pathological elements, and that a more relaxed atmosphere needs to be introduced. Patients were encouraged to talk, read and to do things for themselves, while caretakers responded by trying to create an institutional climate where interpersonal relations could be nurtured (Nolan 1993).

The 1983 Mental Health Act consolidated the 1959 Mental Health Act and the 1982 Amendment Act, and restored to a central place in mental health legislation the legal safeguards for patients. The Act's reforming provisions were in part due to the contributions of MIND. The Act introduced stricter criteria for compulsory admissions with the Approved Social Worker playing a key role. It provided more procedures for reviewing commitment, the strengthening of patients' rights to resist unwanted treatments, a system to protect the rights of informal patients, the reduction of restrictions on patients, and the establishment of a body to monitor practice and patients' rights and to assist in new consent to treatment rules. In order to see through these initiatives, the Act established a new body, the Mental Health Act Commission, and retained the Mental Health Review Tribunal.

The Mental Health Act Commission was established by the Secretary of State and its membership consisted of a chairman and members including doctors, lawyers, nurses, psychologists, social workers and academics. The Commission took up its duties on September 30, 1983. The Commission's functions as laid down by Section 121(2) of the 1983 Act, are: to review the care and treatment of detained patients; to appoint medical practitioners to give second opinions; to provide for a multidisciplinary review of consent to treatment; to draw up a Code of Practice; and to review decisions concerned with the censoring of patients' correspondence.

The Mental Health Review Tribunal which was established under the 1959 Mental Health Act was retained and strengthened under the 1983 Act. Section 66 of the 1983 Act identifies the occasions when a patient or his/her nearest relative may make application to the Tribunal. Applications may be made under the following circumstances (1) a patient admitted to hospital for assessment under Section 2 may apply within 14 days of admission; (2) a patient admitted to hospital for treatment under Section 3 may apply within 6 months of admission; (3) a patient received into guardianship under Section 7

may apply within 6 months of the date of the order; (4) where a patient's diagnosis is re-classified, the patient or his/her nearest relative may apply within 28 days of the date when they were informed of the re-classification; (5) a patient transferred from guardianship may apply within six months of the date of the transfer; (6) where a nearest relative is restricted from making an application for discharge, the nearest relative can apply within 28 days of being told that the responsible medical officer has prevented discharge.

The Tribunal under the 1959 Act had to discharge the patient once the decision was reached. Now the Tribunal can delay discharge, suggest a transfer to another hospital, re-classify the patient to another form of mental disorder or recommend transfer to guardianship (Gostin 1983). Apart from the patient or his/her nearest relative applying to the Tribunal, the Home Secretary can apply for restricted patients and the Secretary of State for Social Services can refer a case at any time. Also the 1983 Act ensures automatic review to guard against patients who do not take the opportunity to apply. Finally the 1983 Act provides for legal aid for patients wanting to be represented before a Tribunal. According to Bean (1986), although the Mental Health Review Tribunal has considerable advantages, the composition of the Tribunal lacks a social worker and so the decision-making process is different from that used for admission procedures.

Gostin (1983) has argued that the basic strategy for mental health reform is the '**ideology of entitlement**', which he saw as having three components. Firstly, the health and social services for the mentally ill should not be dependent on the discretion of politicians, administrators or professionals, but be entitlements enabling the courts to be used to ensure that such rights were not denied. This would allow for remedies where entitlements created by statute through mental health legislations were not being met. It would also be a way of enforcing the allocation of resources to the mental health services to improve conditions in institutions and for developing services in the

community. Secondly, the involvement of non medical personnel in decisions about compulsory admissions, the facilitation of automatic and regular review of individual patients and the limiting of treatment without consent, and so protecting users against abuses of their rights. Thirdly, the maintenance of the civil status of the user, for example the right to vote and to have access to the courts. Such an entitlement would challenge the entrenched social control approach of doctors, caretakers and other professionals and administrators involved in the planning and delivery of services. It would also enable users and carers to exercise legal and political pressure to enforce the rights of people deemed to be mentally ill.

Caretakers were given recognition by the Act. They not only played a part in multidisciplinary consultations, but for the first time they were given the power to detain patients on their own initiative through a holding power valid for six hours.

Mental health legislation has contributed to changes in the work of caretakers and to changes in the civil rights of the mentally ill. Each new piece of legislation brought with it new definitions and new demands. Not all the changes have resulted in improved care for the mentally ill. It could be argued that there has been progression with regard to the civil rights of the mentally ill. However, any assumption along those lines must attend to the evidence which shows that the mentally ill have been socially and medically controlled by doctors, caretakers and other mental health workers.

CHAPTER 12

CONCLUSION

The work of the men and women who care for the mentally ill has traditionally received very little attention. The investigation described in this thesis has sought to inquire into how government policies and legislations influenced the roles and responsibilities of the caretakers and the rights of the 'insane'. The evidence drawn on has included primary and secondary historical sources, and conversations with contemporary caretakers. The study is an attempt to provide original evidence of the changes in the work of caretakers between 1890-1990, and to collate information on how the provision of care and treatment for the mentally ill has changed. It has sought to find out how the mentally ill have been viewed over this period, and what care and treatment has been made available to them.

From attendant to mental health nurse

Since 1890, the care and treatment of the insane, the mad and the mentally ill has undergone many changes. The middle of the nineteenth century saw an unparalleled move towards the institutionalization of the insane in both private and state institutions. Pauper lunatics were accommodated in workhouses and the county borough asylums, while the middle classes were cared for in private madhouses. At this time psychiatry was being developed as a branch of medicine and started to provide the rationale for the bureaucratic supervision and control of the insane. The legislative approach embodied in the 1890 Lunacy Act emphasized safeguards for individuals against unjustified hospitalization, and conceived of the insane as persons with rights. The legislation did not focus on intervention, but emphasized the individual's rights vis-a-vis the state. This was a positive move, even though it was the middle classes, magistrates and commissioners who decided on the soundness of mind of mainly working class individuals. Commissioners, for example, would inspect institutions to assess the adequacy of the physical

conditions, but they did not assess the care given or the clinical decisions that were made.

The 1890 Lunacy Act represented the formalization and legalization of insanity within the asylum. The legal approach to insanity was thought to be protecting sane rational individuals with free will from abuse. For example, individuals who were eccentric and wealthy were vulnerable, as they were likely to be consigned to licensed houses whose proprietors had a financial interest in their continued retention.

The Mental Health Act 1930 changed all these arrangements by rejecting legalism in the interests of the early treatment of mental disorders. This Act marked a sharp break with legal certification and the dominance of the asylum, and its objectives were seen as contributing to public health and voluntarism. The asylums, now known as mental hospitals, retained their dominance alongside the new emphasis on clinics and psychiatric wards in general hospitals. This period saw the ideology of disease and the principles of general medicine imposed on mental treatment, and a move towards the therapeutic state, with state agencies engaged in the provision of care, treatment and cure of social problems.

The caretakers were occupied with rules, routines and cleanliness. The training given concentrated on medical diseases and physical treatments. They saw their job as an occupation rather than as a profession, with most of their interventions dominated by medication and control. They saw hospitals as the best places for patients, although they were also seen as stigmatizing. This, Ramon (1985) argued, probably contributed to the development of the Mental Aftercare Association which favoured the establishment of cottage accommodation for patients at the point of leaving hospital. Some caretakers argued for psychiatric nursing to be given the same status as general nursing.

The 1959 Mental Health Act came into being in the context of the universalist National Health Service. Treatment now included more reliance on ECT, the new psychotropic drugs and the open door policy. The clinical-somatic approach to insanity continued to be the main approach to care and treatment. This approach, however, was increasingly criticized by sociologists, anti-psychiatrists, psychologists, new self-help groups and MIND.

The training of caretakers was now organized and examined by the General Nursing Council and topics such as group work and interpersonal skills were in training programmes. Despite these changes, caretakers accepted that their role was uncritically to carry out medical staff's instructions and prescriptions. For the first time caretakers were working with distressed adults in the community. Some also worked as social therapists. As Community Psychiatric Nurses, most were content with administering doctors' orders. At the same time, social workers, psychologists and occupational therapists were growing in number and participating actively in patient care.

The 1959 Act emphasized voluntary admission, which implied that patients were in hospital out of their own volition rather than through coercion; it afforded greater measures of citizens' rights and hence personal dignity for the patient. Day hospitals were established, together with observation units in general hospitals, domiciliary services and an open door policy, and there was greater use of psychotropic drugs. The negative impact of institutionalization on patients was recognized, and the need for alternatives to care within the traditional hospital was acknowledged. The harmful effects of ECT, psychosurgery and psychotropic drugs, although mentioned, were not taken seriously. People were still staying in hospitals because there were too few alternatives in the community, and continued hospitalization fostered chronicity regardless of the patient's status.

The 1983 Mental Health Act introduced stricter criteria for admissions, whether for assessment or treatment, and required social workers working with the mentally ill and having responsibilities for recommending compulsory admission to be specially trained as Approved Social Workers. Registered Mental Nurses were given the power to detain a patient already in hospital for six hours. This was a major change in the work and role of the caretakers, and was the first time that their custodial role had been formalized.

The Act demands that patient's consent be sought for all treatments except in emergencies, when a one off-treatment can be given. The consent to treatment rules are overseen by a new body, the Mental Health Act Commissioners, whose remit is to protect the rights of detained patients. The Commissioners can receive complaints, monitor the use of the Act and visit hospitals to report on all aspects of a hospital's functions.

The Act had attempted to respond to criticisms by MIND concerning the workings of the Mental Health Review Tribunal. The Tribunal can now overrule the Responsible Medical Officer and discharge a patient, and patients are now granted automatic hearings without having to appeal.

Models of insanity and of caretaking work

Throughout the period 1890 to 1990 the caretakers of the insane have responded to the wishes of superintendents and doctors and their work has been affected by changing legislation. By becoming nurses, caretakers left behind social skills of care and adopted a clinical-somatic approach to insanity. The clinical-somatic approach, although useful, cannot provide for all the needs of the insane, and it is only since the 1983 Mental Health Act that caretakers appear to be trying to regain the social within their work.

Mental health legislation has formed part of a major series of changes in the social treatment of mental illness. First, there was the rise of the asylum and

the capture of this domain by the medical men. Secondly came an extension of the concept of mental illness, along with control and surveillance within and without the asylums and madhouses; and the development of new therapies and professions, notably, social work, psychology, psychoanalysis, the use of drugs and the beginning of the emptying of the asylums. The integration of the legal and the medical, therefore, emphasized the power of psychiatry as a method of defining and regulating social behaviour

The Lunacy Act of 1890, the Mental Treatment Act of 1930, the Mental Health Act 1959 and the Mental Health Act 1983 all brought about changes in policies which affected the work of caretakers and the rights of the insane. Those changes affected the roles and functions of caretakers and established new rights for patients. Associated with the changes in the caretakers' roles were also changes in both medical and public perceptions of mentally distressed persons. This was seen clearly in the changes of the label for such persons, from lunatic, mad and insane in 1890 to mental illness in 1930 and 1959, and mental illness and mental health problems in 1983.

The Lunacy Act of 1890 required caretakers, then called asylum keepers and attendants, to supervise and exercise the insane inmates in accordance to the rules and regulations of the asylum. The attendants kept the institution clean and tidy, maintained order by controlling the inmates and functioned as the medical superintendent's servants. This period saw the shift in public thinking about madness, with madness being seen more as a physiological state than a disease related to possession by devils. With this thinking came the development of the asylum system to replace the haphazard mixture of private madhouses, public workhouses and prisons. At this time the training of caretakers took place in some asylums but it was varied and depended on the views and beliefs of the medical superintendents.

The 1930 and the 1959 Acts saw an influx of psychologists into mental health care. Caretakers remained central to the running of wards while only a minority became involved in community care. The clinical somatic approach to care resulted in most of the caretakers' functions being concentrated with maintaining medication. The same changes, however, made possible the development of caretaker skills including group work, therapeutic community skills, counselling skills and psychotherapy skills. Caretakers were once again emphasizing their role in developing interpersonal therapeutic relationships with patients.

The 1983 Mental Health Act moved the approaches to care and treatment towards a more legal and rights arena, which, while not reducing the clinical-somatic approach, attempted to increase the civil rights of patients.

Social workers were now to be more involved in admission procedures. The Mental Health Review Tribunal was required to respond more rapidly. A new body, the Mental Health Act Commission, was established to ensure good practices and to make sure that the procedures for consent to treatment and second opinion rules were followed. Caretakers were given new powers to detain patients in hospital.

Contemporary caretakers feel that the 1983 Mental Health Act has led to changes in provisions to ensure that patients' rights are respected. They see those changes as inhibiting to some degree patients' rights to care and treatment. They are also concerned about the rights expressed in the 1983 Act and the difficulties which are still evident in ensuring that those rights are achieved.

Caretaking today

The ideology of the caretakers of the insane is usually expressed as an ethic of service. That is, the caretakers exist for the benefit of any member of

society who has need of their expertise. However, there has been a long history of critical opinions which argue that such claims meet the needs of the occupation of caretaking more than they do the needs of service-users (see e.g. Illich 1976; Wilding 1982). Such a critical approach suggests that caretakers seek to control the clients, through the power exercised over individuals. This situation is seen in the power of occupational groups, and the conferring of client or patient status is rejected by groups of people who recognize the impact that such a situation has on their lives (MIND Manchester Group, 1988). Further, terms such as 'client' and 'patient' are socially constructed by the power of health care professionals, casting people thus labelled into a passive role. Caretakers have the people they work with, their service-users, defined for them by psychiatrists. Psychiatrists draw on legal statutes for the power to diagnose and prescribe. Prescription by psychiatrists include assigning tasks to caretakers. Nurses frequently have the knowledge and skills to undertake diagnosis, but these are circumscribed by the power of doctors defending their control over this area of work. Such situations result in nurses developing strategies for influencing doctors (Johnson 1978; Keddy *et al.*, 1986; Schutzenhofer 1988; Damrosch *et al.*, 1987) The caretakers of the insane are in a similar position. Another area of concern derives from the development of modern nursing in the social, political and economic changes of the nineteenth century. This occupation provided openings for work for women within patriarchal structures. The men who were involved in such work were either located at the margins or they managed and controlled it.

What is evident is that caretakers are controlled through the institutions of law and medicine, through the particular structures of their occupational rules and regulations and through the management of settings in which the insane are housed. Caretakers are therefore involved in power and social control processes as a collectivity and as individuals. They are involved in power and social control relationships with the insane. Within this web of power and

social control relationships, it must be remembered that clients/patients are primarily medical labels, and people are constantly in the process of establishing their active identities as service-users, in an attempt to create a situation where they are no longer passive recipients of sometimes questionable services. These ideas concerned with the empowerment of service-users are evident in the work of pressure groups such as MIND and self-help groups organized around a specific theme (Wilson 1987).

Resistance and possibilities for change

Within the framework of the limitations on their work imposed by legislation, professional ideologies, limited resources, and public attitudes, it is clear from this study that caretakers have some capacity to take forward a radical agenda for mental health service provision.

The work of caretakers must be considered as a departure from general nursing. Perhaps a new professional group is required for the future. One thing is clear from this investigation: that, even if the workers with the insane remain within the professional category of nursing, in the future the emphasis on caretaking should be integrated with the nursing and the medical models. This would create a group of workers who would challenge the contradiction within psychiatry whereby it is simultaneously a regulatory social apparatus and a system of treatment and care, and would lead to a new emphasis on the need to empower and protect the rights of the person deemed to be insane. In so doing, caretakers would draw on the ideas of Karl Marx who saw the economic relationships of capitalism as having consequences for social relationships through the process of alienation. They would address the need to work with people at the community level, to know about unemployment, poor housing, low wages and the health of the environment, along with the social, health, welfare and educational services which exist.

As a more political group of care workers, caretakers could become more involved in the political process through joining with user groups to ask for more resources and better facilities to provide care. To ask survivors, were your rights infringed on by the mental health services and how? To ask users and carers, how can the mental health services ensure that rights are respected and not abused?

In order to take on this role, caretakers would need a different type of education - one with more emphasis on the social sciences, counselling, mental health promotion, philosophy and law, along with specialist medical and psychiatric knowledge. These political activities might take place at both the community and the local level, and would include the interrogation of medical judgements and treatments for their effectiveness and safety, and especially the need for more information about the side-effects of prescribed drugs and the use of ECT. Caretakers can insist that any form of therapy, intervention or research acknowledges hidden political and gender issues. They could make more use of the 'conscience' clause in contracts when they are unhappy about participating in procedures with which they disagree. They have the potential to be involved in addressing the social divisions of patriarchy, class and racism, which result in life problems and help to 'produce' mental illness. In so doing, caretakers can prevent the marginalization of feminist issues. They may also seek opportunities to re-educate women to speak out against patriarchy and oppression, and insist that they are listened to. In seeing this agenda through, caretakers could assist women in, according to Ussher (1991), 'dethroning the patriarchs', and developing women-centred practices such as feminist therapy and community projects where women live and work. Such projects could provide for local political action, women's refuges and mental health support. All these activities would be presented in a multidimensional way, using the medical model where it suits women, along with feminist and humanist approaches. For example, a woman might need space away from family and society - an

asylum; and the need for asylum does not mean that people should be locked away, but that they should be provided with safety and space without coercion. Similarly chemicals may be needed to reduce depression, but they should not be seen as the sole cure, only as an aid.

Caretakers are ideally placed to recognize the complexity of mental health and illness phenomena and not just to categorize, diagnose and label women in a one-dimensional way. Caretakers could address women's need for economic support, child support, therapy or medicines, by ensuring that different interventions are available at different times. However, to achieve some measure of help or care for women positioned as mad, the professionals will need re-education.

Caretakers would need to develop a strong sense of accountability as a prerequisite for working with people. This accountability would need to be directed towards the men, women and children who use the mental health services. It would involve a commitment to respond to questions, challenges and the requests of users, and would be rooted in a belief that professional activity is a tool of the citizen and has no essential monopoly on truth or wisdom.

Users may need to emphasize more their role in educating service-providers, including social workers, psychiatrists and caretakers. This would lead to a more positive and collaborative working environment. Caution needs to be exercised here, so that providers who are already working in a problematic area of health care are not demoralized.

Another possible direction for the future is that caretakers build stronger alliances with other professionals involved in caring for the insane and with the various voluntary sector workers, users and survivors, charities and pressure groups such as MIND. Such alliances and interprofessional partnerships would enable co-operation and the sharing of power in the

planning, organization and the delivery of care. Building alliances also involve changes in language and underlying attitudes and values, so that users are enabled to participate more fully in discussion and debate. The work of caretakers is in an important sense rooted in the descriptions of experiences people themselves offer to express their distress.

Activities which exclude users would be challenged. This might mean that users should not be talked about if they are absent; that confidential files should become more freely accessible; and that users are invited to functions from which they have historically been excluded. These activities would facilitate a general recognition of the strength of users.

Taking up the challenge of developing these possible new ways of working and caretaking will not be easy. Caretakers' desire for power and status will still be there. The political, social and economic realities will be the same. But what history teaches us is that the essential power and uniqueness of caretaking work resides in the professional capacity of caretakers to work with, rather than on, those who use the mental health services.

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APPENDIX 1**The Rules relating to the Attendants in the Bethlem Hospital with the Duties of the Several Officers and Servants (1854) London: Bethlem****GENERAL RULE:**

The attendants and servants shall commence their duties at six O'clock in the morning in the summer, and at such time as shall be appointed, not later than seven O'clock in the winter. Their first duty shall be to write their names in the attendance books, to which they shall have access not later than ten minutes after the period appointed for the commencement of their daily services.

RULES FOR ATTENDANTS-DUTIES OF PARTICULAR HOURS

1. The Attendant shall unlock the bedroom doors of all the patients who are in a fit state to be at large; they shall then wash and dress the patients and carefully examine them, in order that any soreness or discolouration of the skin or other changes may be observed, and reported to the Medical Officer at the first morning visit, or immediately if the case appears to require it.
2. The Chief Attendant of each ward shall go to the stores room for bread, butter and milk as required in their respective wards during the day, and shall then return to the store room all excess stores from the preceding day.
3. All spare time before breakfast shall be occupied in cleaning the dormitories, day rooms and galleries.
4. The patient shall have breakfast and special care be taken that those who are in the bedrooms be properly supplied at 8am.
5. Immediately after breakfast, the Attendants shall continue the thorough cleansing of the day rooms, galleries, bedrooms, where not completed, and shall remove all foul linen, and all dirt and litter of every kind, after which the beds shall be made and the bedrooms left open for ventilation.
6. All the patients selected for employment shall be ready to go with several Attendants and Servants under whose care they are to be occupied, and the sick in the infirmaries and in the wards shall be ready for the morning visit of the Medical Officer at 9am.
7. The Attendants shall have completed the cleansing and proper arrangement of their several departments and shall be neatly dressed at 11am.

8. The male patients in out door employment and the female patients occupied in the laundry shall have luncheon, as directed in the diet table.
9. Half of the Attendants on each side of the hospital shall dine in the Attendants' dining room and immediately after their return to their respective wards, the remainder of the Attendants shall dine in like manner at 12 noon.
10. A 12.45 pm. the Attendants in each ward shall be in readiness when the bell rings to receive from the kitchen the patients' dinners.
11. At 1pm. the patients shall dine, and care shall be taken that every patient have a proper supply of food in accordance with the diet table or the directions of the Medical Officer. The helpless shall have their food divided into small pieces and when necessary they shall be fed. The food of patients who are in their rooms shall be taken to them by the Attendants and not by patients.
12. The Chief Attendant in each ward shall be responsible for the return to the kitchen every day immediately after dinner of all the food found to be more than sufficient for that meal.
13. At 5pm. the male patients in outdoor employment shall be brought to their respective wards by the Attendants and Servants who have had the charge of them; and every particular change that have been observed in the appearance or conduct of any of them whilst in occupation to the Medical Officer.
14. The male and female patients shall have tea, after which they shall be encouraged to read, or enter into any of the amusement provided for them.
15. At 8pm. the patients shall be put to bed, and their clothes taken out of their bedrooms. The bedroom door shall be locked and the gas turned off.
16. The night Attendants shall enter on their duties after which the Attendants who have completed their several duties shall be at liberty to leave their respective wards at 8pm.
17. At 10pm. all Attendants and Servants who have been out for the evening, with permission, shall have returned to hospital, and at this

hour all Attendants and Servants, except the night Attendants shall be required to retire to rest.

18. They shall go through the wards at least once in every hour during the night, and shall give proof of having done so by registering the Attendance on the night clock.
19. The first duty of night Attendants shall be to examine the list of patients requiring particular attention, and to ascertain that the food and medicine directed to be given to them during the night have been provided and left ready for use.
20. They shall execute all the orders given by the Medical Officer for their observance during the night, and they shall endeavour to soothe all patients, who are restless, and shall supply their wants as far as may be prudent. They shall also take care that those patients who will not remain in bed be provided with a sufficiency of warm night clothing.
21. They shall watch with special care all patients who are suicidal, or who in any respect require particular attention.
22. They shall ring the night bell of the Medical Officer on the occurrence of any unusual event or where in any patient shall appear to them to require immediate medical care.
23. They shall perform their duties with the least possible noise, and shall have with them at all times a light in lantern provided for their particular use.
24. They shall call up the Attendants whose duty it is to take part in night watch at 2 O'clock every morning, and the Attendants and Servants every morning at the appointed hour by ringing the morning bell, and when the Attendants have taken charge of the wards, they shall send to the Matron or Medical Officer a book containing a written report of the state of the wards and of the patients during the night, after which their duties for the occasion shall terminate.

DUTIES ON PARTICULAR DAYS

- SUNDAY**
1. The Attendants shall see that all the patients be dressed with neatness and that those who are directed to be taken to Chapel be ready in time, and be properly supplied whilst in Chapel with prayer book and hymn book.

2. Patients attending Chapel who are subject to sudden excitement, shall as far as practical be seated with one or more Attendants near the door so that when requisite may be easily removed.
3. No work shall be done which can with propriety be delayed, and care shall be taken that the day be spent in a decorous and becoming manner.

MONDAY 1. Attendants shall take to the laundry such of their own clothing as requires washing.

2. On the first and third Mondays in every month with the exception of Christmas Day, New Years Day, Easter Monday, Whit Monday. The relatives and friends of the patient shall be allowed to see them between the hours of ten and twelve O'clock, but no visitors shall be permitted to see any patient, if the Medical Officer be of opinion that the visit be injurious to such patient or otherwise inexpedient.

TUESDAY 1. All patients in a fit state to be present at prayers, they shall be taken to the Chapel at the appointed time, by the Attendants, who shall perform this duty in rotation as far as their other duties can be suspended for the purpose.

2. The Attendants superintending the patients in the work room shall take to the store rooms all the clothing and articles made by the patients during the preceding week, and shall receive a supply of work for the current week.

WEDNESDAY Every male patient shall be shaved.

THURSDAY The patients and Attendants shall attend Chapel on Thursdays.

SATURDAY 1. Every patient with such exceptions as the Medical Officer shall direct, shall have a bath, the temperature shall not be lower than ninety degrees nor above ninety eight degrees unless be special order. The patients shall remain in the bath long enough for the purpose of cleanliness, and on being taken out shall be rubbed until they are quite dry.

2. The Chief Attendant in each ward shall receive from the store rooms the allowance of tea, sugar, soap, candles. as required in the wards during the week, and shall at the same time return to the store room all excess of these stores remaining with each from the preceding week.
 3. The Attendants shall fetch from the laundry the clean linen and clothing of their respective patients.
 4. Every patient shall be provided with clean linen and all dirty linen shall be taken to the laundry as a general rule, all foul linen shall be taken to the laundry at the earliest convenient opportunity.
 5. Every male patient shall be shaved.
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APPENDIX 2

INTERVIEW SCHEDULE

SECTION 1

- a. How long have you worked with the insane?
- b. In what capacity have you worked with the insane?
(one of or in a combination of the following or other) Nursing Assistant, Staff Nurse, Charge Nurse/Sister, Community Nurse, Teacher, Manager.
- c. Please describe for me what your current work with the insane entails.

SECTION 2

The four questions which follows are asking you specific questions. I would like you to answer these, and in addition to extend your answers into any other themes/ issues relevant to you which the question suggests.

1. What do you think is the function of Mental Health Legislations in relation to:
 - a. clients/patients deemed to be insane.
 - b. the work and role of the 'caretakers' of the insane.
2. With reference to the 1959 Mental Health Act how much dose this Act relate to:
 - a. the work/role of 'caretakers'
 - b. the responsibilities of 'caretakers'
 - c. the civil rights of the insane.
3. With reference to the 1983 Mental Health Act how much does this Act relate to:
 - a. the work/role of 'caretakers'
 - b. the responsibilities of 'Caretakers'

- c. the civil rights of the insane.
- 4. Are there any other government legislations since 1890 to the present which have affected:**
- a. the care given to the insane by 'caretakers'
 - b. the civil rights of the insane.
- 5. Please give me an example/examples of a situation/situations where you felt the following may have played a part in your work:**
- a. social control
 - b. civil rights issues.
- 6. Please think of your career as a 'Caretaker. Can you remember any situation/situations when you felt your work and role met with or did not meet with your expectations vis-a-vis the care given to the insane.**

PAL/1992

APPENDIX 3

108 Oakdene Road, St. Mary Cray, Orpington, Kent BR5 2AW

Dear

I am researching the history of the 'Caretakers' of the insane, and the influence of government legislation and policy on their roles and responsibilities.

Information is sought from contemporary 'Caretakers' with a focus on the 1959 and 1983 Mental Health Acts.

The areas which will guide the information collection are:

- a. the role of Mental Health Legislation
- b. the role and responsibilities of the 'Caretakers' of the insane vis-a-vis the 1959 and 1983 Mental Health Acts
- c. the relevance of any other government legislation on the work of 'Caretakers'
- d. government legislation and the Mental Health Acts of 1959 and 1983 and the civil rights of the insane.

If you are willing to participate, I am asking the following of you:

- a. to meet with you for an introductory discussion to answer your questions, to exchange information and to plan the interviews (approximately 45 minutes).
- b. to interview you (approximately 45 minutes)

I have worked for many years as a psychiatric nurse. The areas of legislation, the civil rights of the insane and the role and responsibilities of the 'caretakers' of the insane have always been of interest to me.

This research is a part of my PhD programme at the Institute of Education London University. It is my intention to try to get the final report or parts of the final report published. If publication is achieved your identity will be protected.

Throughout all the research activities your identity will be kept in strict confidence and data will not be shared with any other agency.

I will telephone you approximately two weeks after you have received this letter to discuss further your questions, possible cooperation and hopefully plans for an introductory meeting. I can be contacted at the above address or by telephone. Telephone number - 01689 876905

I look forward to your participation in this research
I am,

Yours Sincerely,

Tony Leiba.